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ACCESS TO HEALTH AND LONG-TERM CARE

HEARING

BEFORE

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ST. LOUIS PARK, MN

MAY 25, 1989

PART 1

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ACCESS TO HEALTH AND LONG-TERM CARE

THURSDAY, MAY 25, 1989

THE PEPPER COMMISSION
U.S. BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE
St. Louis Park, MN.

The Commission met, pursuant to notice, at 9:15 a.m., at the Park Nicollet Medical Center, St. Louis Park, MN, Hon. Dave Durenberger (Vice Chairman of the Commission), presiding.

Present: Senator Dave Durenberger.

Also Present: Edward F. Howard, general counsel; Steven C. Edelstein and Philip Shandler, professional staff.

OPENING STATEMENT OF CHAIRMAN DAVE DURENBERGER

Chairman DURENBERGER. Thank you, ladies and gentlemen, for the opportunity to be here with you today.

I want to begin by expressing all of our collective appreciation to the Park Nicollet Medical Center for being our host and hostess this morning for this what I believe someone will someday characterize as a historic event.

I would like to thank the Senior Federation and a lot of others who had a role in not only bringing signs but opportunity for a lot of Minnesotans to be here with us today as well, and to thank the staff of the Commission, and my own personal staff, especially Mary Edwards here in Minnesota, whom all of you have come to know during the period of time that I have been working on these health care issues, for making this day possible for all of us.

H.G. Wells said that civilization is a race between education and catastrophe. We are here today to educate ourselves on how to avert an impending catastrophe in the American health care system, the system which has been recently described as being a paradox of plenty and of want, a system where some receive the benefit of the most advanced medical technologies of the world, yet a poor woman can't get decent prenatal care, or a family can't get help to keep a frail parent from having to go into a nursing home.

As vice chair of the U.S. Bipartisan Commission on Comprehensive Health Care, I am proud that the very first public hearing of this potentially historic Commission is being held in my State of Minnesota. I only regret that the health of our esteemed Chairman Congressman Claude Pepper keeps him, who is responsible for the existence of this Commission, from being here with us today, because I know how much he would have loved being part of this particular moment in history.

In particular, we on the Commission are concerned with the problems of the 37 million Americans who lack even basic health insurance benefit and the burgeoning need for long-term care service, especially by the frail, the elderly, and disabled persons.

As the vice chairman of the Commission, I am proud to bring to the attention of my colleagues in Washington the unique experiences of Minnesota employers, insurers, health professionals, and State government in grappling with these same problems.

Let there be no doubt, the problems are severe. We spend a high proportion of our gross national product, about 11½ percent, on health care, and it is more than in any other nation of the world. And yet nearly 37 million Americans have no protection from the expenses of medical care either private or public.

Even more disturbing is the fact that our current system of financing benefits systematically denies coverage to many who need it most, those who have preexisting medical conditions or those who have sought treatment for alcohol or drug abuse. Benefits are often not available to seasonal, part-time, or self-employed persons, to early retirees and others whose employers choose not to offer coverage. More than two-thirds of the uninsured adults belong to the labor force, and yet they and their children lack basic protection.

This lack of protection exacts a high cost, postponement or denial of needed treatment, needless pain and suffering, and depletion of personal savings.

Separately, long-term care financing will become more pressing in the next decade. Long-term care refers to a wide array of medical, social, and personal support services needed by people who have lost some capacity for self-care due to a chronic illness or condition. Today in America, despite the threat of viral illnesses like AIDS and hepatitis, 80 percent of all deaths and 90 percent of all illnesses are related to chronic illness.

The seriousness of this problem has been marked in the past by the fact that private and personal resources and care cover the vast majority of all long-term care costs. But that private support system is eroding fast.

America is aging and living longer. At the turn of this century when my father was born there were only 100,000 Americans over 85 years of age. By the time in the year 2050 that my youngest son reaches my father's age today there will be nearly 13 million Americans over 85.

There are 37 million Americans today with disabilities. We are spending $75 billion a year in Federal revenue, $20 billion in State revenue, and nearly $80 billion a year in private revenue on people with disabilities without providing them with adequate access or a majority of them with adequate access either to medical care or to work.

The average age of America's veterans is 68 and aging. All are entitled to medical and long-term care services, mostly under Veterans' Administration programs, a national responsibility to millions of Americans of astronomic size and consequence to our Federal budget.

The formation of the Bipartisan Commission on Comprehensive Health Care is an unusual and an exciting coalition of primarily

congressional leaders committed to rectifying the inequities in the availability and financing of health benefits in the United States. Unlike other commissions, this one has the power to actually act on what it recommends.

The Commission was established by the same law that brought us catastrophic benefits under the Medicare Program. Although we eliminated some important gaps in protection of the elderly and disabled, larger even more difficult problems are clamoring for resolution.

If we are a civilized society, and I believe that we are, then we must rectify the shortcomings of the current health care delivery system that limit or prevent access of all people in the United States to comprehensive health care, and we must do it immediately.

It is unconscionable that a nation of such wealth as ours allows so many people to go without even basic interventions to relieve pain and suffering. This is especially disturbing when we realize that the people in question have the least in personal resources and are among our most vulnerable.

These demographic trends and expenditure levels will strain private resources as well as budgets of public programs. Further, there is a wide divergence of views on what the public and the private sector roles should be in reform. This is as true for the most immediate issue of the uninsured as well as for future financing of long-term care services.

I share the goal of securing access to basic health insurance benefits for all Americans. Since employment is the major route by which most people obtain health benefits, the private business sector must play a role in our efforts to obtain greater parity across all kinds of employees.

As we are learning in Minnesota, if we don't act quickly to provide a national program of access to health care for all Americans, our State legislatures will act to mandate these services. As Americans, we cannot and must not relegate health status to the accident of residence in America.

I suggest, however, four important principles we will need to agree upon before we reach our goal of health care for all Americans. These principles will guide me as I participate in the deliberations of the Bipartisan Commission between today, its first hearing, and the middle of November of this year when we issue, hopefully, our final report.

The first principle is universal access to health care. Every American must have membership in a health plan which provides financial access to health care and manages the provision for them of all medical services.

Second, employment as access. Practically all Americans depend on earnings for the purchase of health care. We must expand this opportunity to all employed persons by changing the current tax treatment of employer-provided health care benefits to eliminate the tax preferences for large employers, those who can more readily pass on costs in the prices of goods and services, and higher paid employees, and to eliminate the current discrimination against small employers, against low-paid workers, and against self-employed persons.

Third, social insurance as access. For those who are retired, disabled, unemployed, or whose earning levels are low, the Social Security Act can and it must be reformed to supplement earnings as a source of premium payments for medical benefits and to supplement earnings and savings to pay for long-term care benefits for all Americans.

And, fourth, we must accelerate reform of provider payments, utilization, and quality of health care standards.

This Nation will not have the financial capacity to provide its citizens with universal access to basic health care including long-term care unless we move quickly to deal with our failures in measuring quality of care and its value, our failures in provider payments that are equitable across medical specialties and regions of our country and of our State, and our failures in the unnecessary and inappropriate use of medical services.

With these thoughts in mind, I welcome the testimony we will hear today. I expect it to contribute significantly both to the sense of urgency that these problems must be solved and to pointing the way to their solution.

[The prepared statement of Chairman Durenberger follows:]

STATEMENT OF SENATOR DAVE DURENBERGER - U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE - May 25, 1989

It has been said that "civilization is a race between education and catastrophe". (H.G. Wells). We are here today to educate ourselves on how to avert an impending catastrophe in the American health care system, - a system recently described as being a paradox of plenty and want. A system where some receive the benefit of the most advanced medical technologies in the world, yet a poor woman can't get decent prenatal care or a family can't get help to keep a frail parent from having to go into a nursing home.

As a Vice-Chairman of the U.S. Bipartisan Commission on Comprehensive Health Care I am proud that the very first public hearing of this

potentially historic commission is being held in my state of Minnesota. I only regret the health of our esteemed chairman Congressman Claude Pepper, keeps him from being here today.

In particular, we are concerned with 1) the problems of the 37 million Americans who lack even basic health insurance benefits, and 2) the burgeoning need for long-term care services especially by the frail, elderly and disabled.

As a Vice-Chairman of the Commission, I am proud to bring to the attention of my colleagues in Washington, the unique experiences of Minnesota employers, insurers, health professionals and state government in grappling with these same problems. And let there be no doubt, the problems are severe.

We spend a higher proportion of our Gross National Product (about 11.5%) on health care than does any other nation. And yet, nearly 37 million Americans have no protection from the expenses of medical care, either private or public.

Even more disturbing is the fact that our current system of financing benefits systematically denies coverage to many who need it most - those who have pre-existing medical conditions or who have sought treatment for alcohol or drug abuse. Benefits are often not available to seasonal, part-time or self-employed persons, early retirees and others whose employers choose not to offer coverage. More than two-thirds of the uninsured adults belong to the labor force, yet they and their children lack basic protection. This lack of protection exacts a high cost: postponement or denial of needed

treatment, needless pain and suffering, and depletion of personal savings.

Separately, long-term care financing will become more pressing in the next decade. Long-term care refers to a wide aray of medical, social and personal support services needed by individuals who have lost some capacity for self care due to a chronic illness or condition. Today, despite the threat of viral illnesses like AIDs and Hepatitis, 80% of all deaths and 90% of all illnesses are related to chronic illness. The seriousness of this problem has been marked in the past by the fact that private and personal resources and care covered _____percent of all costs. But that is eroding fast.

America is aging and living longer. At the turn of this century when my father was born, there

were only 100,000 Americans over 85 years of age. By the time , in 2050, when my youngest son reaches my father's age today, there will be nearly 13 million.

There are 37 million Americans today with disabilities. We are spending 75 Billion Dollars a year in Federal revenue, 20 Billion Dollars in State revenue, and nearly 80 Billion Dollars in private revenue on them currently without providing adequate access for a majority of them to either work or get medical care.

The average age of American veterns is 68 and aging. All are entitled to medical and long-term care services, mostly under veterans administration programs.. a national responsibility to _____ Americans of astronomic size and consequence to the Federal budget.

The formation of the Bipartisan Commission on Comprehensive Health Care is an unusual and exciting coalition of primarily Congressional leaders committed to rectifying serious inequities in the availability and financing of health benefits in this country. Unlike other Commissions, this one has the power to actually act on what it recommends!

The Commission was eatablished by the same law that brought us catastrophic benefits under the Medicare program. Although we eliminated some important gaps in protection of the elderly and disabled, larger, even more intractable problems are clamoring for resolution. If we are a civilized nation, and I believe we are, then we must rectify the shortcomings in the current health care delivery system that limit or prevent access of all individuals in the United States to comprehensive

health care.

It is unconscionable that a nation of such wealth as ours allows so many people to go without even basic interventions to relieve pain and suffering. This is especially disturbing when we realize that the people in question have the least in personal resources and are among our most vulnerable citizens.

These demographic trends and expenditure levels will strain private resources as well as the budgets of public programs. Further, there is a wide divergence of views on what the public and private sector roles should be in any reform. This is as true for the most immediate issue of the uninsured as well as for future financing of long-term care services.

I share the goal of securing access to basic health

insurance benefits for all Americans. Since employment is the major route by which most individuals obtain some form of health benefits, the private business sector must play a role in our efforts to obtain greater parity across classes of employees. As we are learning in Minnesota, if we don't act quickly to provide a national program of access to health care for all Americans our State Legislatures will act to mandate these services. We cannot and must not relegate health status to the accident of residence in America.

I suggest, however, four important principles we will need to agree upon before we reach our goal. These principles will guide me as I participate in the deliberations of the Bipartisan Commission.

1) UNIVERSAL ACCESS TO HEALTH CARE

Every American must have membership in a health plan

which provides financial access to health care and manages the provision of all medical services.

2) EMPLOYMENT AS ACCESS

Practically all Americans depend on earnings for purchase of health care. We must expand this opportunity to all employed persons by changing the current tax treatment of employer provided health care benefits, to eliminate the tax preferences for a) large employers, b) those who can more readily pass on costs in the prices of goods and services, and c) the higher-paid employers, and to eliminate the discrimination against small employers, low-paid workers and self-employed persons.

3) SOCIAL INSURANCE AS ACCESS

For those who are retired, disabled, unemployed, or whose earning levels are low, the Social Security

Act can and must be reformed to supplement earnings as a source of premium payments for medical benefits, and to supplement earnings and savings to pay for long-term care benefits.

4) ACCELERATE REFORM OF PROVIDER PAYMENTS, UTILIZATION AND QUALITY STANDARDS.

This nation will not have the financial capacity to provide its citizens with universal access to basic health care, including long-term care, unless we move quickly to deal with our failures in measuring quality of care and value, in provider payments that are equitable across medical specialities and regions of our country, and in the unnecessary and inappropriate use of medical services.

With these thoughts in mind I welcome the testimony we will hear today. I expect it to contribute

significantly both to the sense of urgency that these problems must be solved and to pointing the way on how to solve them.

-30-

Chairman DURENBERGER. I now welcome from Washington, DC, where I understand the House may still be in session for various reasons that don't have anything to do with health care, my co-vice chair of the Bipartisan Commission the esteemed Congressman from Cincinnati, OH, and the ranking member on the health subcommittee of the Ways and Means Committee of the U.S. Congress, Congressman Bill Gradison.

Somehow he is going to magically appear.

[The videotaped statement follows:]

Representative GRADISON. Although I can't join you in person today, I am delighted to have this chance to take part in this indirect way in what I am sure will be a productive hearing in Minnesota. Dave Durenberger is one of the most respected members of either House of Congress when it comes to health. And we can count on him to make this hearing a solid first step in our Commission's public information gathering process.

Because of Dave's involvement and because of its enormous potential, I am very excited by the possibilities that this Commission presents for progress in addressing two of America's greatest social problems, the tens of millions of people with no health insurance or inadequate protection, and the virtually complete lack of protection against the hazards of expense for long-term care.

It won't be an easy task. There are dozens of knotty policy issues we have to address. And we have to address them in a very short timeframe. But I think we can address them humanely and responsibly, and I look forward to working with Senator Durenberger and my other colleagues on the Commission to that end.

Chairman DURENBERGER. OK. Thank you, Bill Gradison.

Our third vice chair is Senator Max Baucus of Montana who served on the Senate Finance Committee with me. And Max is apparently on his way to Montana this morning and was not able to appear in that form. The next hearing is going to be in Missoula, MT. For any of you who happen to be in Montana toward the end of June, you can participate again at that time.

Now, thanks to the experiences that we have had in Minnesota over the last several years, which build up to the fact that the Nation will now address the problem of comprehensive health care, we have all come to know some very, very special Minnesotans, people not only with special needs but with the gift to articulate the needs not only that they have but that they believe represent the needs of literally hundreds of thousands of our fellow citizens in Minnesota and millions of our fellow citizens across the United States of America.

So the honor of being the first person to testify before the U.S. Bipartisan Commission on Comprehensive Health Care goes to Diana Seeger who is the mother of four children, and I think we are going to see some of those kids right there, whose family had no health insurance when she had her fifth child. And she is going to describe for us that particular situation and what it meant for her family.

Diana, thank you for being here.

STATEMENT OF DIANA L. SEEGER, GRAND RAPIDS, MN

Ms. SEEGER. Hello, my name is Diana Seeger. I live in Grand Rapids, MN, with my four children. My children's ages are 20, 16, 5, and 3. My first two children were raised without our having any medical insurance.

If you have never raised a family without medical insurance or medical assistance, it would be difficult for you to understand the terror that parents face at 2 o'clock in the morning when they awake to find that the crying baby is running a temperature of 106. Of course they call the hospital, and hope that the person on the other end of the line doesn't think they should bring the baby into the emergency room. They hope that they can handle the care at home. But high temps can be dangerous so they better bring the baby in.

This is a reoccurring nightmare that does not end at the first light of day, the nightmare for the baby, but the next morning there is also a nightmare of how are they going to pay the $100 emergency room charge. This is a commonly shared nightmare of families without medical insurance.

But this, as bad as it is, is only the beginning; 6 years ago I was pregnant with my third child. My husband Melvin was working as a logger bringing home about $9,000 a year. I was not employed. We had no health insurance. And our assets were too great for us to qualify for medical assistance. So I regularly drove 70 miles to the Indian hospital in Cass Lake, MN, for prenatal care. We knew that when the time came we would have to go 84 miles, 14 miles farther, to a hospital in Bemidji, MN, because the Indian hospital did not do deliveries. There were two hospitals within 20 minutes of our house, but the costs were way out of our range.

Well, the time came and we were on route to the hospital—we did not make it; 25 miles into the trip I went into labor and we wound up at an Indian outclinic. They were not equipped to handle deliveries. They had no forceps. They didn't even have oxygen.

The doctor at the clinic called the ambulance from a hospital that was 5 miles away, one which we had just passed. The ambulance came quickly but not quick enough. By the time David was delivered he had been deprived of oxygen for 8 to 10 minutes of his life. As a result he was severely brain damaged.

David was then rushed to the hospital in Duluth, MN, 70 miles from our home. He spent the first 3 months of his life there. He was home for about 2 weeks, and then he had to be rehospitalized in Deer River for pneumonia. He was in Deer River for 2 weeks, and then he was transferred 200 miles to Ramsey Medical Center in Minneapolis where he stayed off and on, mostly on, for the next 6 months.

When David was ready to be released, it was decided that he would be put in a medical foster home in Minneapolis so that he could be close to the hospital. At that time David needed 24-hour care. He had a feeding tube and he needed to have his lungs suctioned out for fluids.

We would have liked to have been able to care for David at home ourselves, but without any home care or respite care there was no way we could do it. Since Grand Rapids had no such programs of support services, we just couldn't keep David with us.

So after all that we had been through we had to arrange through social services for a family in Minneapolis to take care of David. I would drive the 200 miles once or twice a month to visit him. People used to come up to me and say: "Oh, they must be wonderful people." But when you are a mother who loves your children,

it's the hardest thing to hear. I wanted to say: "They are paying them $1,000 a month. If they would help me half that much, I could have taken care of my own child." Over the next 2 years David needed three additional surgeries. When he was 1½ years old, he needed tubes in his ears to prevent ear infections and recurring pneumonia. Around that time he also had a gavage feeding tube stapled into his stomach. He was aspirating fluid into his lungs, which was also causing pneumonia. Later, when he was about 3, he had to have the feeding tube readjusted.

Shortly after the last surgery when David was 3½ years old, he died.

Had we had health insurance or would have been eligible for medical assistance, we could have gone to a hospital that was closer and David would be alive today. The bitter irony of this all is once he was handicapped David had all the medical care he needed. The cost of his care for his short life was $183,000, all of which was paid by medical assistance.

This year I paid in $3,000 Federal income tax. Prenatal and maternity coverage in our area is about $2,000. It only makes good financial sense to invest $2,000 to save $183,000.

As for the moral issue, an entire family went through months of counseling and years of agony. A baby suffered for 3½ years. I blame David's death on a system that doesn't care enough about its children to provide or help provide medical insurance for those in need. And in a country that is rich in resources our baby's life was taken because someone thought they could save $2,000. My story is only one of thousands.

Chairman DURENBERGER. Thank you, Diana. That experience has already made a difference in a lot of people's lives, and today you have taken another very large step forward.

Our next witness is Sue Stevens whose home is in St. Louis Park, MN. And Sue is a single parent with a 12-year-old daughter who has chronic health problems. Sue, thank you for being here.

STATEMENT OF SUE STEVENS, ST. LOUIS PARK, MN

Ms. STEVENS. Good morning. My name is Sue Stevens, and I am a single mother. And I live right here in St. Louis Park with my daughter Jennifer who is now 12 years old.

When Jennifer was born I was on welfare and all our health needs were taken care of. I worked hard to get off welfare. I went back to school and eventually found a full-time job working at a craft store.

When I was hired I told my employer that I would take a lower salary but that I needed to have health care coverage for me and my daughter. He readily agreed. But it turned out to be much easier said than done. The place where I work does not have a lot of employees. There are five or six people at the warehouse. Two of them are the owner's wife and son. The two stores are staffed mostly by women who work part time, and they're usually covered under their husband's insurance policies. Because of this my employer is too small to qualify for an open-door policy where all the employees are automatically covered regardless of any preexisting health problems.

Jennifer suffers from allergies and asthma. And I have the allergies, asthma, and high blood pressure. So my employer's regular insurance carrier will not take us on. We checked with other insurance companies, with HMO's, and nobody will cover us because of our preexisting health problems.

When Jennifer was younger she had had adenoid problems, perforated eardrums, ear infections that required tubes in her ears, and bladder difficulties that resulted in surgery. But we had coverage then through Medicaid. If she had those problems today, I don't know what I would do.

Not long ago I noticed some suspicious spots on my arm and I worried about skin cancer. Luckily a local clinic was running a free skin cancer screening. They examined the spots and said that I should have them checked out. I went to my dermatologist. Biopsies were performed and the spots turned out to be benign. But I was a nervous wreck until the results came in. The bills would have been bad enough; but if I hadn't been able to work, I would have never been able to have gotten out from under it.

Fortunately, since last September when our insurance ran out, we both have been pretty healthy. We both do fine as long as we take our prescriptions. For a while we were going without our medications because we couldn't afford them. Between the two of us the prescriptions run close to $200 a month. I make $6 an hour and it's tough fitting $200 a month medications into our budget. But things were far worse when we didn't take the medication, so somehow I have managed to find the money to pay for them. But I had an additional $300 in medical expenses last March, and I am still behind.

If Jennifer were younger, she would qualify for Minnesota's Child Health Plan, and I wouldn't have to worry so much. If I worked for a bigger provider, then we'd both be covered under his insurance. If we didn't have these health problems, we could get coverage from any number of health insurance companies or HMO's.

But isn't that what insurance is for: Taking care of our health problems? If we were well all the time we wouldn't need it. And the funny thing is that as long as we take our medications we don't have the health problems and it wouldn't cost them a lot for doctor and emergency room visits.

I worked hard to make a good life for Jennifer and myself, but I don't know how long I can go on having to worry each day whether our next health problem is going to drag us under completely. Thank you.

Chairman DURENBERGER. Thank you, Sue, very much.

Now our third witness—and so everyone understands there is some logic to each of these witnesses. We are examining the issues of access with these first three witnesses. And we can't examine all of the problems. But I think each of our witnesses have done a very good job of showing us how substantial the access problem is and how difficult it is to live with the system that doesn't recognize that if you paid a little money up front you would save an awful lot of money somewhere else.

Now, a person who has been instructive on this for all of us in Minnesota for even more years than she appears to have lived is

Grace Nelson of Edina who is a member of the board of directors of the Minnesota Board of Aging, Group Health, and the Medicare Advocacy Project; the past president of the Minnesota Senior Federation; and a past vice president of the Metropolitan Senior Federation. Grace Nelson.

STATEMENT OF GRACE NELSON, EDINA, MN, REPRESENTING THE MINNESOTA SENIOR FEDERATION, THE MINNESOTA HEALTH CARE COALITION, AND THE MINNESOTA LONG-TERM CARE CAMPAIGN

Ms. NELSON. My name is Grace Nelson. I am representing the Minnesota Senior Federation, the Minnesota Health Care Coalition, and the Minnesota Long-Term Care Campaign.

As one who has faced the problems associated with paying for the acute care of my husband and the nursing home care for my mother, I know first-hand the complexities and costs of our present system.

Our health care system is expensive, bureaucratic, and often cruel, a statement also made by Dr. John Roberts, chief resident in internal medicine at Abbott Northwestern Hospital.

Our current system of providing health care is costly. Almost 12 percent of our gross national product, which is a higher percentage than other countries with national health care coverage. Too, with this high cost we have almost 40 million uninsured. Higher costs and the number of uninsured indicates that competition is not working. With fragmentation of our system, increasing administrative costs, paperwork, and time diverted from on-hand care by providers of health care, fragmentation also lends itself to cost shifting.

The current system is unfair in the following ways: Inequality of rural and urban reimbursement; inequality of reimbursement, which overpays many specialists by penalizing primary care physicians' reimbursement; inequality of access to care. The bottomline tends to be cost, not quality. No money, no care. Little help for chronic care. Screening out individuals with expensive care problems. And a lack of attention to long-term care.

The following are our recommendations. In the long run we recommend comprehensive universal health care for all Americans. In the first phase [applause], in the first phase there should be a consolidation of all public medical funding sources and then evolving into Medicare Part C. Coverage under Medicare Part C should include comprehensive long-term care services, including home care. The program should provide benefits intergenerationally and be funded intergenerationally with a general progressive intergenerational income tax as needed. We oppose the means-testing of benefits.

As to comprehensive universal health care, we recommend a one-payer system, a basic coverage which includes acute care, long-term care, home care, prescription drugs, mental health, dental health, and preventive care. The program should be funded by a percentage paid by employers, employees, individuals, and an additional tax revenue as needed. In all health care planning consumers, recommended by their organizations, must be involved.

To close with two quotations. This one comes from an anonymous source. "We are connected by a common link. With one end we sit, with the other we think. Our success in life depends on which end we use. Heads we win, tails we lose." [Laughter and applause.]

The second quotation I would like to give is from Winston Churchill. "Americans can always be relied on to do the right thing after they have exhausted all other possibilities." [Laughter.]

We hope that with this Commission the heads will win and Churchill's words will not be true as it applies to the lengthy process.

We want to thank you for the ability to make this presentation, Senator Durenberger.

Chairman DURENBERGER. Thank you, Grace, very much. [Applause.]

Now, Grace has provided us with a transition between acute medical care and long-term care. And our next witnesses will be people who can speak to us of the need out there for long-term care services, long-term care financing. The first of the witnesses is Floyd Weese who is—I think his home is in Buffalo, is that right?

Mr. WEESE. Right.

Chairman DURENBERGER. And we originally met in St. Cloud——

Mr. WEESE. Right.

Senator DURENBERGER [continuing]. At one of these hearings. But Floyd Weese is a 75-year-old with a 24-hour-a-day job, which he is going to describe for us right now. Floyd.

STATEMENT OF FLOYD WEESE, BUFFALO, MN

Mr. WEESE. My name is Floyd Weese, and I live between Buffalo and St. Michael, MN, Wright County. I live on my farm that my grandfather moved onto in 1893 with 11 children. I was born and raised on that farm. And when I got married my wife and I farmed there, and we have been farming there ever since. We raised five children on that place.

And my wife Deena now has Alzheimer's disease and Parkinson's with other complications setting in. She needs 24-hours-a-day care. My children do help as much as they can, but are all busy working and taking care of their own families, and I understand that. When there is an emergency they are always there to help me.

The help I get from home health care from the county had been good. The nurses, home health aides, housekeepers are also good. I also get meals on wheels from a nice local restaurant, which is in St. Michael. Home health care has been discontinued to 1½ hours per week. The county nurse comes twice a year. Housekeeping help is on my own. I do have other help that comes in to care for my wife. I pay for them myself.

All these programs are good, but are very expensive. There is little funding. It seems when we want the help that isn't there because of expense, we also need money for supplies such as Depends, diapers, bedpans. There is a difference in need for funding for meals on wheels in the rural area. There are also no caregiving meetings in Wright County due to the lack of Federal funds, and our State was cut back here a year or two ago.

There is also no benefits for home health aides or housekeepers. The pay is low. There always seems to be quite a turnover in the county there. It seems like they can go out into a restaurant nowadays and make more money on tips than they can working at that kind of a work.

I could use some night care, to get away in the evenings a little bit, and care in the daytime for me to conduct business. I also need weekend care. A couple of years ago I had to have knee replacements, so my wife went into a nursing home in Monticello while I had that done. My wife told me many times not to put her in a nursing home, but I had no choice.

She was almost blank when she was in that nursing home, and she had been in the hospital three times last year and she was the same way there. She just could not comprehend anything. We are in contact with Dr. Frye at St. Paul Ramsey Hospital and an Alzheimer's group down here in Minneapolis and St. Paul. I do fill out questionnaires for the VA Hospital, University of Minnesota, and some of the research departments. So we are connected with them. Also my wife when she passes away will have an autopsy which will show for sure whether she has Alzheimer's or not. That's the only true way to find out about that.

I am a full-time caregiver, 24 hours a day. I get up in the morning. I look at my wife to see that she is all right. I then feed her breakfast, after I put all of her food through a blender. Her food needs to be blended because she can no longer chew solid foods. Her liquids must be thickened with a thickener, such as water or juices and so on. After her breakfast she gets her bath, teeth brushed, mouth rinsed, hair combed, dressed, heat applied to her sore spots. People who are in bed and in a weak condition do have sore spots. And now with the summer coming on, heat, humidity, it gets pretty bad, and it's a full-time job. And, boy, some days you just don't know how to cope with it.

After she rests in bed for a little while I do her exercises. I then prepare dinner, feed her, and then she goes back to bed for a nap. She sits up in the afternoon and supper is prepared. After supper I wash her and get her ready for bed.

During the night I get her up once usually and change her. There are times she fills up with fluid and she coughs. That is quite a job sometimes to solve, and sometimes I am up all night with that.

Something we are badly in need of is some catastrophic health insurance for nursing home care. In my situation where I am keeping my wife at home, I could use some help through some type of insurance. We only have Medicare at the present time. We had a good HMO, but our clinic had to discontinue it because they were falling behind too much with funds. And that would help me an awful lot if they had some help for that.

Now, the new insurance that they came out with this year, I have looked it over. And of course it's always next year and next year and next year and next year. And I think by the time they get to where I am, probably we will be gone. I would like to have something in there that helps me. And so far the way it is I can't see anything down the road for the next year or so. It will be more costly for us. That it will be.

And I also agree very much with Grace Nelson. I could go on. But she has said an awful lot in there that I would like to say. So take your next man here.

Chairman DURENBERGER. Thank you, Floyd. [Applause.]

I hope that through the medium of television people across this country will learn the value of beginning these hearings in the Heartland rather than on the east coast where so many of these things begin. I was just thinking to myself as Floyd was talking about Alzheimer's (al-zen-heim-ers), that he comes from Wright County which is very close to Stearns County where I come from, which is Lake Wobegon to a lot of folks out in Minnesota. [Laughter.]

And whether it's Alzheimer's (alz-heim-ers) or Alzheimer's (al-zen-heim-ers) or oldtimers, as it used to be called, it is a problem that the rest of America ought to understand is being dealt with in a very special way in rural America.

And what a value it is to the rest of this country, those family values of Floyd and his wife who are still on the farm, being able to care, provide that care, in a way that is much more difficult to accomplish in the rest of this country. And if anybody wants to think of a good reason why we ought to hang on to rural America and we ought to hang on to the smaller farms and we ought to hang on to the small towns and everything else, it's because it's really very healthy for the rest of this country to do that. And I think we just heard an illustration of that.

Mr. WEESE. Could I say one thing?

Chairman DURENBERGER. Well, yes.

Mr. WEESE. There has been quite a bit of money, research money, through you this year that is given to research in this area. And we thank you very much for that.

Chairman DURENBERGER. Thank you very much.

Now, Grace said earlier: "Heads you win." Our next witness is Reverend Joe Head who is a retired minister, one of the leaders of the Liberty Bell Foundation. He has been disabled since 1983 following a bus accident. His wife also has a disability. But Joe is best known for the fact that he broke the international 100 yard dash record in the San Diego Senior Olympics when he was 73 years of age in 1973.

So, Joe, we are pleased to have you here today.

STATEMENT OF REV. JOSEPH HEAD, MINNEAPOLIS, MN

Reverend HEAD. Mr. Chairman, my name is Joseph Head. I am a retired minister, the past national chaplain of the Veterans of Foreign Wars, a former high school principal and coach, and, prior to my accident, a world champion runner. I am 90 years young, my wife is 85 years, and I have lived in Minneapolis for the past 35 years. We have been happily married for 65 years. [Applause.]

Six years ago I was hit by a bus while on the sidewalk. As a result I was totally disabled and confined to a wheelchair.

Over the past few years my wife developed a circulatory problem with her legs which caused ulcers to form on her legs. Recently the condition worsened and she became completely bedfast. Her legs

were in such bad condition that we were told that unless she was hospitalized she would lose her legs.

Once she was in the hospital, tests were run. She was placed on antibiotics and a dermatologist's formula was applied to her legs. Her legs showed marked improvement, but my wife had an adverse reaction to the medication. Her back and buttocks became inflammed. There was a large red area about the size of a catcher's mitt.

Despite this the hospital wanted to send my wife home. My wife's doctor arranged for her to stay another week. The hospital wanted to release my wife to a rest home, but this was not acceptable to her. If she had gone to the rest home, I would have been left alone. This would have created great difficulties for us. If I had fallen, I might not have been able to call for help in time. In addition, my wife has always handled our family finances. It would have been hard for me to take them over at this late date.

She was released from the hospital about a month ago. Contrary to the requirements of the law, the hospital failed to notify me of her release. They just sent her home by ambulance.

Her back and buttocks were still greatly inflammed, and she was on a catheter. The first night she was home we had a terrible time because I didn't have time to make arrangements for her return.

When she first came home, a nurse came out every day to change the dressing on her legs. After a while this was reduced to every other day. Now the nurse comes twice a week to teach my wife how to change her own dressing, which is very painful for her since it requires her to sit up and put pressure on the inflammed areas of her back. Soon the nurse's visits will end completely.

A nurse's aide who comes to our home is a big help. She bathes my wife, washes her hair, and empties her commode. But we will only have her for 2 more weeks.

The Minneapolis Age and Opportunity Clinic sends a woman out once a week for 3 hours to clean the house, do the laundry, run errands, and shop for groceries.

I do what I can to tend to my wife's needs. I fix our breakfast in the morning and a modest lunch. We get meals on wheels delivered during the day and I heat it in the microwave oven for our dinner.

With my wife's bedridden condition and me confined to this wheelchair, maintaining ourselves in our home is not easy. We can't drive so we can't leave the house for any reason on our own. Our physical limitations make housekeeping and home maintenance almost impossible.

I served my country in World War I. In 1976 my wife and I traveled around the United States with a replica of the Liberty Bell, as a volunteer, speaking to children about patriotism and the glories of our free enterprise system. We went to 36 States, and I talked to over 1 million children.

We have been together for many years, and we have relied on each other. We still depend on each other, but now that's not enough. We need help to stay together in our own home. We love this country and have always done our part. But now here we are helpless and not getting all we need. I thank God for my country and for the places that I have served, but this is as a volunteer paid for by the different veterans organizations of which Senator

Durenberger and others have helped tremendously. So we submit to you that we do need help on long-term care for two patriots who have served their country.

Chairman DURENBERGER. Thank you, Joe. [Applause.]

Our final witness, Mr. and Mrs. Bob Opland from Duluth. And I guess, Bob, you are going to have a statement about your commitment and your wife's commitment to your 75-year-old father.

STATEMENT OF BOB OPLAND, DULUTH, MN

Mr. OPLAND. Good morning. My name is Bob Opland. I am here today with my wife Betty. We live in Duluth with our three children, ages 13, 11, and 17 months, and my father Einar who is 75.

I have been taking care of my father for the past 6 years. He is in general poor health. He was recently diagnosed with cancer, has severe emphysema, arthritis, poor eyesight, hearing loss, and war wounds which have left him partially disabled. And, in addition, he has recently been discharged from the hospital after ulcer surgery.

As a result of his medical conditions, he has only limited mobility which allows him to walk short distances with the aid of a walker. He cannot dress or bathe himself, and he is sometimes incoherent. He requires a lot of care now, but we know as time goes on his condition will deteriorate until he needs round-the-clock care. His emphysema will require him to be on oxygen, and the cancer will make his activities more and more limited.

During the time my father has lived with me I have done what I can to see to it that his needs are met. Not long ago I married Betty, and I have tried to maintain a normal family life for our children. But it's been hard.

Since Betty and I were married 2½ years ago, much of the burden of caring for my father falls on her. She does the best she can to hold everything together. We have a 17-month-old baby, and for Betty caring for the baby and caring for my father are pretty much the same. The demands are the same, but the care is a lot harder because my dad is bigger and he resists her help.

Between my father and the kids things are very hectic for us. As it is, my wife does the household errands during her lunch hour, except the grocery shopping because she can't get the bags home on the bus.

We get approximately 50 hours of home care a week, to cover the period when my wife and I are at work. For a fee of $200 a month the county provides 33 hours of the care. That's for my dad. The other 17 hours we pay for ourselves at about approximately $75 a week. Because of cutbacks in county services, when my father's condition worsens, he will not be eligible for any more assistance from the county. That means the cost of any additional care will fall on us.

Right now we fill in the rest of the hours ourselves. We are on duty evenings and weekends. And for a couple that's been just recently married that means we don't get much privacy. Sometimes we don't get 10 minutes alone together. It's funny, but one of the reasons we looked forward to come down here was we'd have a chance to spend 2½, 3 hours on the drive together talking about finances and plans for the future on the drive down to the cities

from Duluth. You know, so that was a pleasure, something we don't normally get sometimes. Some days it's just unbelievable.

I don't know what things will be like when my dad's condition gets worse. His care will use up more and more of our time and our resources, just as our older children become teenagers, a time when their demands on our time and money will also grow.

My family and marriage already show strains at times, you know, due to the caring for my father and his demands, and I don't know what's going to happen when things get worse. I just don't know.

Chairman DURENBERGER. Bob, thank you.

Mr. OPLAND. Thank you. [Applause.]

Chairman DURENBERGER. Thank you all for sharing your personal lives and your values and your commitments with all of us. I couldn't think of an experience the Nation could have that would better illustrate the need that there is out there and the way with which we in society could reward the commitment that each of you has already made. So I thank you very much, for all of you are volunteers and all are willing to talk with us all about your personal experiences. And I know that you are going to make a difference. Thank you very much, all of you. [Applause.]

We are now going to call our next panel. And I think this next panel we are going to have seven. We are going to call the first three witnesses on what we call the panel 2 here. The first three are people for whom we all have a great deal of respect here in Minnesota for their understanding of the policy implications of the problems just described by these six witnesses.

The first is Representative Paul Ogren who represents district 14-A in the Minnesota House of Representatives and has represented that district for the last 9 years. He currently chairs the House Health and Human Services Committee. And most of you know him as the author of the health span bill to provide coverage for all uninsured Minnesotans, which was considered in the 1989 session of the legislature.

The next witness is Dr. Kevin Fickenscher who is the director for the Center for Rural Health in Grand Forks, ND. He has been the director of the center for the last 9 years. He is probably the preeminent American on the issues of rural health care, has appeared before the various committees of the U.S. Senate and the U.S. Congress, and has recently accepted appointment as the assistant dean of the College of Medicine at Michigan State University. So he will be moving from one part of the Heartland to the other. But if I have to think of a person who has helped us move in the direction of equity for rural America, it would be Dr. Kevin Fickenscher.

Our third witness is a person who here in Minnesota has made all of us pay greater attention to our societal neglect of opportunity and how much that is costing us here in Minnesota. As the director of the Minnesota Children's Defense Fund for the last 4 years Luanne Nyberg has led the Children's Defense Fund not only in a very unique analysis of the problems that face young mothers and children and families across the State of Minnesota in a series of hearings and a study report that was delivered, but she has now committed herself and the Children's Defense Fund to work on closing the gap in affordable health care and providing financial

access to health care for all, not only all Minnesotans but by her testimony here today to all Americans.

So we welcome the three of you. And we will begin with Representative Paul Ogren. Paul, thanks for being here.

STATEMENT OF REPRESENTATIVE PAUL OGREN, MINNESOTA HOUSE OF REPRESENTATIVES, DISTRICT 14-A

Representative OGREN. Senator, thank you for coming to us on this question.

Health care is a primary need. It's primary as the education that we provide our children. It's primary as the housing that we attempt to guarantee to the homeless. It's as primary as the nutritional needs that we attempt to meet at the kitchen table. It is not recognized in our constitution at the State or Federal level as such, but it is recognized, I think, universally by us as such.

In Minnesota we are fortunate. Fewer of us in fact are without health insurance in our society here than in virtually any other State in America. Only one State, the State of Rhode Island, has a smaller portion of its population that is in fact exposed without access to health insurance. But even at that it still means between 340,000 and 400,000 of us in Minnesota have no health insurance, have no basic access to care.

Of those without access to care fully one-third are children; 85 percent are under the age of 45. Almost half of them are not what we would term poor but are in fact earning 200 percent or more than the Federal poverty level. Statewide, those that tend to be without insurance are often in farming, in retail trade, in small employment, or self-employment. But, overwhelmingly, those without health insurance, access to health care in our State of Minnesota, are working men and women and their dependents, their children.

And what does that mean? It means that when they end up in the system they end up at the tail end of the system. They end up in hospitals rather than doctor's offices. They end up with injections rather than pills. Once they enter the hospital, those without health insurance are between two and three times more likely to die in that hospital as are the rest of us that have health insurance. Those without health insurance are five times as likely to leave the hospital against the specific recommendations of their doctors as the rest of us. Our children without health insurance are far less likely to have well child care, far less likely to receive basic immunizations. Our pregnant women are far less likely to receive prenatal care.

The results are unfortunate but I think rather clear. We can't pretend that the costs are not borne and borne by all of us collectively; they are. Much of them in obvious ways through cost shifting. We all pay higher health insurance premiums. We all pay higher property taxes.

Right here in Hennepin County we pay over $16 million every year now for uncompensated care costs provided to the uninsured simply at Hennepin County Hospital and Clinic. And that cost is duplicated again and again in our society throughout the State.

At the State level we pay higher income taxes, higher sales taxes, because we have constructed over time an unfortunate system that says to people: "If you cannot work or if in fact you choose not to work, we will provide you a certain level of care, in fact, a quality level of care through medical assistance. But if in fact you do work and are not enfranchised with employment that guarantees health insurance, you shall go without." People stay on the system of welfare, stay on medical assistance, in many instances because they have young children and simply cannot leave them exposed. And we all bear that cost.

We bear the collective cost of higher absenteeism and lower productivity in the work force. And we bear an ultimate cost of a society that is increasingly stratified, as more and more people in our society, not simply here in Minnesota, but throughout America, go without health insurance. As the economic nature of our society changes, this problem is exacerbated and the numbers are increasing at a geometric progression.

The response is one that I would hope could be borne on a Federal level, a comprehensive response. And I applaud your efforts in that respect, Senator Durenberger. But in lieu of a Federal response it's absolutely imperative the States step forward and establish a model of behavior that can be embraced at the Federal level. If there are 400,000 Minnesotans without access to care today, we know that there will be 440,000 next year at this time and 500,000 the year after that. And while we may not be amongst them, our children may be, or our parents may be, or we may be laid off of our employment and we may be in those same lines.

States are taking the lead in many respects in terms of providing access to health care, the State of Oregon in recognizing that perhaps transplants are not as imperative as prenatal care to pregnant women, the States of Hawaii and Massachusetts that say as a predicate to employment we should have access to care, that we all benefit from that access to care, here in Minnesota with our initial health span efforts.

Senator, thank you very much. We applaud your efforts. We hope you take the message back that we need this help and we need it desperately right here in your State. Thank you.

[The information presented for the record by Representative Ogren follows:]

May 5, 1989

HEALTHSPAN OVERVIEW
(H.F. 150)

The Healthspan legislation is a direct response to the recent studies conducted by the Department of Health, the Citizens League, the Health Planning Board, the Department of Human Services and others which have all shown that up to 10% of Minnesotans do not have health insurance.

These 350,000 to 400,000 people do not have the basic access to the same health care system which most of us take for granted. The results of this inequity are quite startling.

In the Twin City metropolitan area the uninsured (27,000 discharges in 1986, 1987 & 1988) leave the hospital against medical advice up to five times as often as privately insured individuals. This same group of uninsured are at least twice as likely to die as a result of hospitalization as any insured group other than Medicare. Over 80% of this group is under the age of 45.

The studies have shown that 75% of the uninsured adults work full-time (40%) or part-time/seasonal (35%) and half of these uninsured earn over 200% of poverty. About 35% of the uninsured are children.

HF 150 provides for a system which will help these people become insured for their primary health care needs. The benefit plan covers routine physicians office visits ($5 copay for most visits) and hospitalization up to 30 days. The entire benefit package has a $50,000 lifetime maximum. The benefits do not include mental health, chemical dependency, chiropractic, dental, physical therapy, eye glasses or hearing aids.

The funding mechanism for this program comes from two basic sources. The individual who participates in the program will pay up to 100% of the premium depending upon their income level. The second source will be from a one percent (1%) payroll tax on all employers who do not offer health insurance or do not pay at least 50% of the premium for health insurance.

This payroll tax is fully credited to all employers who offer health insurance and pay at least 75% of the premium. Thus only the employers who do not meet the health insurance requirements will pay for the program. This is not a burden when you compare the 1% payroll tax to the 6% to 8% cost of payroll which most employers pay for private health insurance coverage.

Of the 350,000 to 400,000 uninsured in Minnesota, we estimate that up to 25% may be eligible for public programs or employer based insurance but are not currently participating. Therefore, the number reflected in the cost is 300,00 eligible participants. The annual individual premium is just under $1,000 per year so the total cost for the program is approximately $290 million a year. The attached actuarial reflecting medical assistance program costs and the sliding fee schedule help explain the total dollars involved.

26-995 0 - 90 - 2

May 5, 1989

HEALTHSPAN ESTIMATED COST
(H.F.150)

		Note
1987 AFDC adult cost	$80.45	(1)
1987 AFDC children cost	$32.63	(1)
1987 Weighted average cost	**$64.51**	**(2)**
Inflation of costs to 1990 at 8% per year	+$16.75	(3)
Adjustment to bring payments up to market rate (+20%)	+$16.25	(4)
Administrative cost adjustment (+11%)	+$10.73	(5)
Less actuarial adjustment for 30 day hospital limit and lifetime benefit maximum (-8%)	-$8.66	(6)
Less actuarial adjustment for co-payments and (-3.1%)	-$7.58	(6)
TOTAL 1990 ESTIMATED COST PER ELIGIBLE MONTH FOR AFDC POPULATION	**$96.49**	
Less adjustment reflecting 30% of adults to males at 1987 cost of $45/month	-$15.44	(7)
TOTAL MONTHLY PREMIUM	**$81.05**	
ANNUAL PREMIUM	**$972.60**	
ESTIMATED NUMBER OF ELIGIBLE PARTICIPANTS	**300,000**	**(8)**
TOTAL ANNUAL COST	**$291,780,000**	
DOLLARS RAISED FROM SLIDING FEE	**-$160,700,000**	**(9)**
STATE ANNUAL COST	**$131,080,000**	
ESTIMATED REVENUE FROM 1% EMPLOYER TAX	**+$160,000,000**	**(10)**
MARGIN	**$28,920,000**	

May 5, 1989

NOTES

(1) The 1987 medical assistance costs for AFDC recipients were figures provided by the Department of Human Services. These figures are attached.

(2) The weighted average cost per eligible month is a blended rate that assumes that 2/3 of the Healthspan pool will be adults and 1/3 will be children.

(3) The 1987 costs were inflated to 1990 at a rate of 8% per year. This inflation rate reflects recent inflation in the medical component of the CPI.

(4) The inflated 1990 blended rate was increased by an additional 20% to assure that the Healthspan payments to providers or insurers would be closer to the market rate and would cover the costs of providing health care. Medical assistance, which is the basis for these numbers, is generally considered to pay less than the actual cost of health care services provided. With this adjustment, the state's program would pay for services at 120% of the medical assistance payment rates.

(5) The 11% administrative cost adjustment was added to assure that payments would cover administrative overhead costs.

(6) Medical assistance has no lifetime limit on healthcare costs or maximum length of hospital stay. This 8% actuarial adjustment in the costs reflects the $50,000 lifetime maximum and 30-day maximum hospital stay in the Healthspan program. This adjustment was based on monthly cost estimates developed for a major HMO. The additional 3.1% reduction in costs reflects the co-payments and $500 maximum on pharmacy costs included in the Healthspan program that are not available to reduce medical assistance costs. The co-payments help reduce costs directly by requiring the patient to pay a share of the cost. They also help contain costs because they discourage inappropriate use of health care resources.

(7) The adult AFDC population is largely female. Based on actuarial cost estimates prepared for a major HMO, the premiums for 35-year old females are approximately twice the premiums for 35-year old males. Therefore, a cost estimate based on medical assistance costs for AFDC recipients may be significantly higher than the actual costs for a Healthspan program that would include a more balanced mix of males and female in the risk pool. The adjustment for the alternative cost estimate assumes that an additional 30% of the adults are males and that their 1987 monthly cost was $45 rather than $80. This change would reduce the composite average cost per eligible month for the Healthspan program in 1990 by approximately $15.

(8) The 300,000 eligible participants is based upon Healthspan being the payor of last resort. Many of the lower income uninsured will be eligible for public programs. Some employed uninsured will take insurance with their employer.

(9) Sliding fee scale - see attached chart.

(10) The $160 million represents a 1% payroll tax on those employers that do not offer insurance or do not pay at least 50% of the premium. Overall, this payroll tax will be placed on 35% of total payroll in Minnesota.

May 5, 1989

AMENDED HEALTHSPAN SLIDING FEE SCALE

Income as a percent of the poverty standard		Number of people in group	Income		Enrollee share of premium	Monthly cost to enrollees	
			Individual	Family of 4		Individual	Family
Poor	under 125%	131,834	under $6,963	under $14,563	0%	$ 0	$ 0
Low income	126-200%	65,002	$ 6,964-11,140	$14,564-23,000	15%	12.32	37.58
Lower Middle	201-250%	56,574	$11,141-13,925	$23,001-29,125	50%	41.05	125.25
Upper Middle	251-300%	37,713	$13,926-16,710	$29,126-34,950	75%	61.58	187.88
Upper	301% +	111,684	$16,711 +	$34,951 +	100%	82.10	250.50

This scale raises $160.7 million a year from program participants, using enrollee share of premium figures applied to the Department of Human Services' estimates of family and individual premium costs and estimates of group sizes.

DHS has not estimated how many of the poor group are Medical Assistance eligible. However, the state's cost per person on MA is only about 1/3 the cost of full subsidy of the Healthspan premium ($367.20 per year for an individual, versus $985 for Healthspan, and $1120 for the average family, versus $3,006 for Healthspan).

May 5, 1989

ORGANIZATIONS INDICATING SUPPORT FOR HEALTHSPAN

AFL-CIO
Minnesota Conference of Catholic Health Facilities
Senior Federation
AARP
AFSCME
Minnesota Farmers Union
Communicating for Agriculture
Land O'Lakes
Minnesota Public Health Association
Childrens Defense Fund
Minnesota Medical Association
Minnesota Hospital Association
Minnesota Nurses Association
Carondelet LifeCare
Council of Hospital Corporations
Fairview Hospital
North Memorial Hospital
Minnesota National Health Care Coalition
Health Ensurance Coalition
Minnesota Social Services Association
Minnesota Catholic Conference
Lutheran Coalition for Public Policy in Minnesota
Joint Religious Legislative Coalition
Minnesota Board on Aging
Minnesota Ambulance Association
Heartland Community Action Agency
Childrens' Hospital Group
Community Clinic Consortium
Model Cities Health Center
St. Cloud Hospital
St. Paul-Ramsey Medical Center
Jobs Now Coalition

May 5, 1989

HEALTHSPAN COST CONTAINMENT FEATURES

(1) Hospital admission precertification

(2) Concurrent review of hospital stays.

(3) Discharge planning.

(4) Hospital bill audit prior to discharge.

(5) Primary gatekeepers.

(6) Claims data analysis.

(7) Drug formulary.

(8) Pharmacy data analysis.

(9) Bulk discounts.

(10) Emergency room use.

(11) Outpatient surgery oversight.

(12) Protocols for preventive care and common acute care.

(13) Practice data compared to peers.

(14) Practitioner rewards, penalties.

JAN 10 1989

JANUARY 9, 1989

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Update

Employers do not have to report dependent care expenses on W-2

WASHINGTON—Employers will n have to report reimbursements for d pendent care expenses on employee 1988 W-2 salary statements, the Intern Revenue Service said last week.

In special relief Notice 89-13, the II said the W-2 reporting requireme would be waived for 1988 if employe maintain adequate records concernir dependent care expenses and furnish written statement—by Jan. 31—to ea employee showing dependent care e

Continued on next pa

Health plan costs top 10% of pay: Study

By JERRY GEISEL

WASHINGTON—The average cost of family medical care coverage will hit $3,000 per employee in 1989, if health care inflation does not subside.

Last year, employer and employee contributions for family comprehensive medical coverage climbed 11.9% to $2,700, up from $2,412 in 1987, according to a just-released survey by The Wyatt Co.

"It is an alarming cost. It means that for many employees, medical care coverage well exceeds 10% of compensation," said Lance Tane, a consultant in Wyatt's New York office and chairman of Wyatt's group-flex practice.

In view of the enormous costs involved, employers now should rethink their benefit plan design, he said.

"Is the purpose of a medical plan to pay for ordinary expenses or is it only to pay for significant, unanticipated expenses that cause hardship?" he asked. If companies believe that it is the latter, then a closer, more strategic look at how their plans are designed is needed, Mr. Tane said.

Costs also are soaring for individual and employee-and-spouse health care coverage.

For example, employer and employee contributions for individual coverage jumped 14.3% to $1,056 in 1988 from $924 in 1987. And, during the same period, employer and employee contributions for employee-and-spouse comprehensive medical care coverage shot up 11.7% to $2,292 from $2,052.

Faced with skyrocketing medical costs, employers are shifting more group health care expenses to employees.

For example, among a core group of 376 employers surveyed by Wyatt in both 1988 and 1988, 14% last year required employees to pay at least $75 a month toward the cost of the premium for comprehensive medical care coverage, up from 9% in 1988.

On the other hand, employees paid less than $10 a month toward the premium at just 2% of the core group employers last year, down from 9% in 1988.

At the same time, employers are stepping up implementation of medical care cost con-

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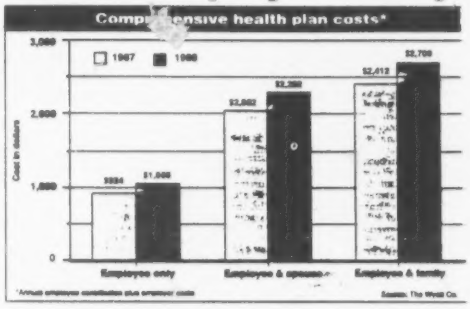

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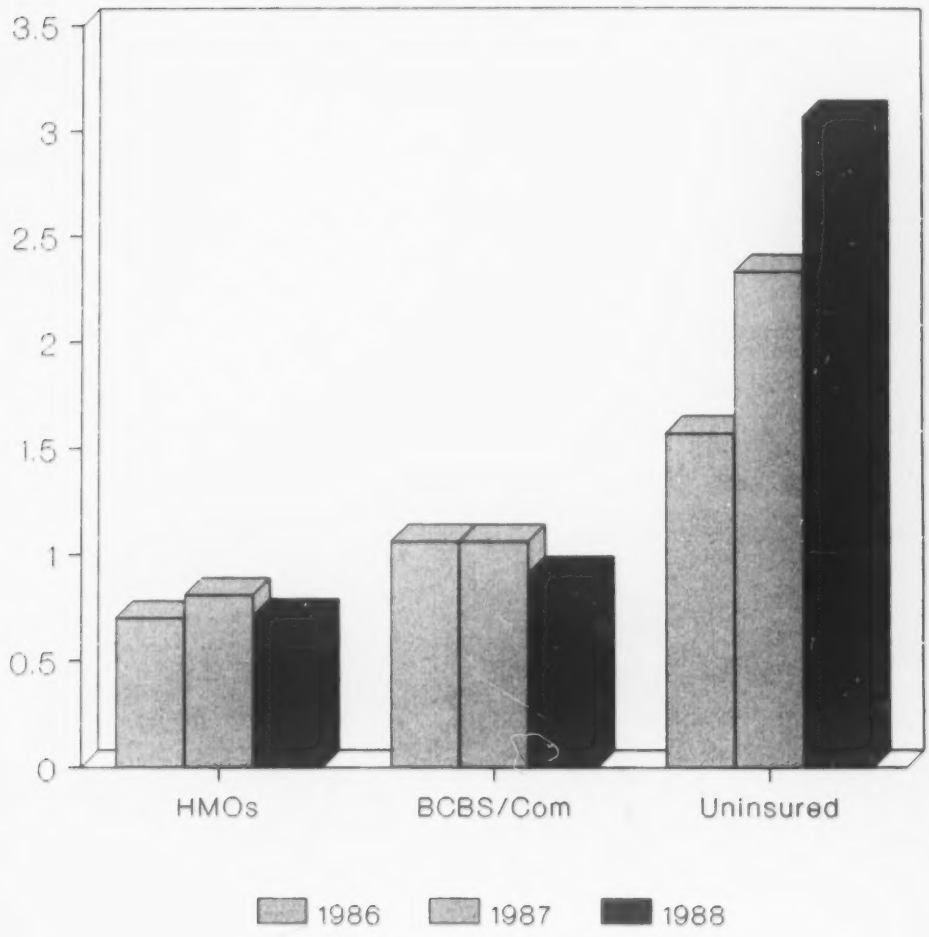
Plaintiffs and insurer defendants in antitrust suit join to oppose five reinsurers' motion to dismiss

% OF DISCHARGES EXPIRED 1986-September 1988



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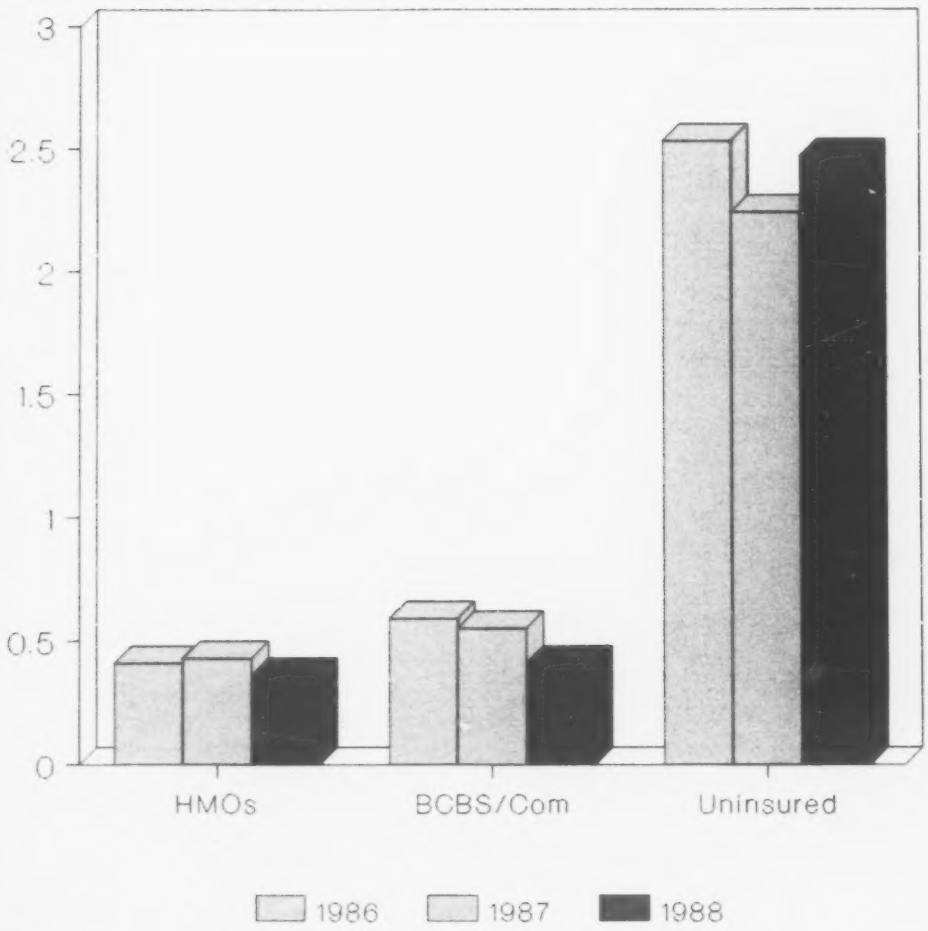
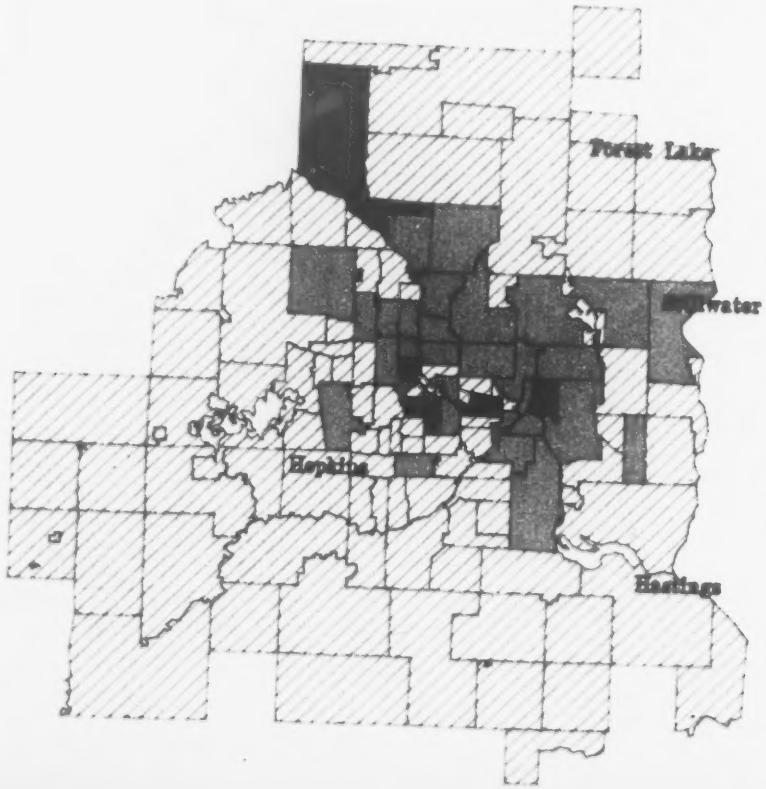


CHC Information Services

Twin Cities: Uninsured Patients
1986 – SEPTEMBER 1988



# of Uninsured pats. **

1 to 103

104 to 262

263 to 374

375 to 565

566 to 848

** Each range represents 20% of the uninsured patients.

Chairman DURENBERGER. Thank you very much, Paul. [Applause.]

Our next witness is Dr. Fickenscher. Kevin, thank you for being here.

STATEMENT OF DR. KEVIN M. FICKENSCHER, DIRECTOR, CENTER FOR RURAL HEALTH, UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, ND

Dr. FICKENSCHER. Thank you, Senator Durenberger.

I want to express appreciation to you for bringing the Bipartisan Commission on Comprehensive Health Care to Minnesota. I really agree with your statement that it's important for commissions like this to come to the Heartland where many of our problems exist and to hear what people have to say.

I was very moved by the statements that came before us. And, in fact, in some ways as I was thinking about my presentation, I thought, that the technical discussions about how we put together a health care system really pale in comparison to the human elements of health care in America. For too long we have neglected, from my perspective, access to basic health care services for our people. For too long we have had a health care system that has suffered from benign neglect. And it's through efforts like the Commission that I think we can now begin to have a discussion in this country about what type of health care system we want to have for the next century. I look to the Commission for leadership in helping us to frame that debate because it is so critical for so many people in the country.

I am here today to talk to you about rural health and about some of the rural issues because that's something that I know best.

One in four of all Americans reside in rural areas. One in three of all elderly reside in rural areas. And half the Nation's poor are in rural areas. Those are some stark statistics that I think outline the problem.

The other thing about rural health and rural health care delivery is that we cannot talk about rural health without talking about the health of rural America. And even though this is a Bipartisan Commission on Comprehensive Health Care, I think when it comes to rural health care that we also need to talk about rural infrastructure. We need to recognize that we can't sustain rural health care if we don't have a healthy economy.

There are many considerations before Congress related to rural development—about what to do to sustain the Heartland. I would agree with you and your statement that the Heartland is important. And I would encourage the Commission to not only consider issues related to health care but how we are going to sustain the infrastructure that is able to provide the services in our rural portions of the country.

As you so aptly pointed out, 37 million Americans are uninsured. I know six of them: My brother, his wife, and his four children. They don't have access to health care because he is a lumberjack. And his income fluctuates, and it goes according to the national economy. When times are good, like they have been for the last 12 months, things are OK. But when I heard this morning on the

radio on the way over here that our GNP is slowing down, that people are projecting that we are entering a recession, one of the first things that happens is that housing starts go down, and my brother is unemployed.

And so it's an issue that not only is something that is felt by the people who were on this panel before, but it's also felt by people like myself who study health care and try to figure out how can we deliver health care to people not only sitting at this table but are part of our families, that are part of our neighbors. Because really when you stop to look at the problem, it's people that live next door. Those are the ones that are suffering when it comes to health care.

There are a number of issues that I have outlined in my paper that relate to various issues on health care for the poor and the uninsured, and I would encourage you to consider them. I think one of the things that I want to point out is that the level of poverty in rural America is increasing quite dramatically. It's not going down. It's getting a lot worse. And, as a matter of fact, the degree of poverty in rural America is 50 percent greater than it is in urban America. Poverty is not in the south Bronx. It's not in Washington, DC. It's in rural Minnesota. It's in Iowa. It's in the hills of West Virginia. And it's in northern California. It's in all the rural places of this Nation. And we need to recognize the problem.

Rural America has some unique problems in that it is very difficult for people who reside in rural America often to gain access to the insurance system. They're self-employed. They cannot take part in employer programs in many cases. And as a result, the costs that they have to bear related to health care is substantially higher than some of their urban counterparts.

As we look at the health care system, I applaud the four elements that you outline. I think that those are essential in our discussions for health care. In addition to those, I would urge the Commission to consider several other elements.

One, I think we need to invest our national resources in primary and preventive care. One of the things that I have really come to realize is that if we put our money over there, the health care system will move over there. If we put our money here, the health care system will move over here. The health care system is very sensitive. So wherever we put our dollars, wherever we invest them is very important.

Finally, we need consumer participation. We need to have a dialog that exists between Government, consumer, business providers, and the insurance industry. We need to integrate services at the local level.

There are a number of specific recommendations that I have made in my formal paper which I would urge the Commission and the staff in particular to review. Because of limited time, I won't go into those at this point. Suffice it to say that I think we need a rural development policy because we can't have health in rural America unless we have a healthy rural America. We need to restructure our Medicaid Program so that there is equity in it in all States. And we also need to consider legislation that I think would

create State risk pools to help in insurance for people that live in rural areas.

Thank you very much.

[The prepared statement of Dr. Fickenscher follows:]

CONSIDERATIONS IN POLICY DELIBERATIONS RELATED TO THE DELIVERY OF HEALTH CARE SERVICES FOR RURAL IMPOVERISHED AND UNINSURED PEOPLE

Kevin M. Fickenscher, M.D.
Director, The Center for Rural Health
University of North Dakota
Grand Forks, North Dakota

Statement before the
United States
Bipartisan Commission on Comprehensive Health Care
Minneapolis, Minnesota

May 24, 1985

Members of the United States Bipartisan Commission on Comprehensive Health Care:

On behalf of the rural health community, I want to express my sincere appreciation to the United States Bipartisan Commission on Comprehensive Health Care for inviting me to share some thoughts with you on the important issues related to the delivery of health care in rural America. My name is Kevin Fickenscher. I am a board-certified, Associate Professor of Family Medicine and Assistant Dean with Michigan State University College of Human Medicine. Until this past week, I served as the Director of The Center for Rural Health at the University of North Dakota, the only university-based health sciences research and policy analysis program in the country devoted exclusively to issues concerning rural health. In addition, I am a Past President of the National Rural Health Association, a multi-disciplinary association of health professionals devoted to enhancing health care services for rural people throughout the nation. These multiple roles have provided me with a broad array of experiences in education and research which coupled with my experiences in working with rural communities throughout the nation represent the framework for my comments today.

The Commission has a very important set of tasks to accomplish over the next six months prior to submitting its report to the U. S. Congress in November, 1989. Although the members of the Commission are an exception, for too long health care has not received adequate attention by our nation's policy-makers, for too long we have neglected the need to provide access to a set of basic health care services in the nation, for too long our health care system has suffered from benign neglect. Now is the time to begin an active debate on how best to provide <u>quality</u> health care that is <u>accessible</u> at a reasonable <u>cost</u>.

The critical questions surrounding health care have been on the nation's back burner long enough. I look forward to the report of the Commission on these most important issues as we set the framework for discussions on how best to organize our health care system for the next century. In particular, I am pleased that the Commission requested input on aspects of our health care system in rural America. The delivery of health care for fully one-fourth of our nation's population is an important issue which needs your attention.

To effectively discuss the issues involved in rural health I believe it is essential to consider a common definition of rural. Too often "rural" is lumped together as one large group which does not recognize the inherent diversity and complexity of the rural regions of the nation. We do not place all urban areas into a common category of "city".

Certain common definitions have evolved over the last two years. First, the common definition used by the Department of Labor for rural are those counties of 100,000 population or less referred to as Standard Metropolitan Statistical AReas (SMSAs). Another common definition used by the Bureau of the Census defines rural is any place with a population of less than 2,500 people. All data and most research which has been accomplished on rural areas uses one of these two definitions.

Two other subcategories of rural include: adjacent rural and frontier areas. Adjacent rural areas are those adjacent to SMSAs. The characteristics, resources, and needs of these communities appear to be quite different than the more traditionally defined rural community. Frontier areas are generally defined as those areas of 6 people per square mile or less. ([1]) Research on the inherent differences of health care in frontier areas has only recently begun. As a result, it is difficult to quantify the characteristics of these areas at the present time. On an anecdotal level, however, it would appear that there are considerable differences in frontier areas from more traditional rural areas. One of the primary issues is the lack of available resources in virtually all categories for sustaining any level of service. This problem is particularly acute for rural health where it is generally accepted that rural people have the same rights to basic health services as their more urban counterparts. The sparsity of the population creates another problem with the cost of sustaining services. As an example, the cost of emergency medical services averages $10 - $12 per capita in urban areas; $20 - $25 in traditional areas; and, in excess of $50 per capita in frontier areas depending upon the population density. These two definitions have yet to be clearly delineated. It would appear, however, that including the definitions in examining health services would more clearly define such considerations as access to health manpower.

Rural America possesses a number of common strengths and weaknesses that affect the type and level of health care services provided in rural communities. Weaknesses evident in rural America include: 1) a lack of sufficient critical mass to support selected programs and services; 2) a fluctuating economy dependent upon agriculture, forestry, extractive industries, or small manufacturing industries; 3) transportation difficulties due to the lack of public systems; 4) a general shortage of professionals despite excellent opportunities in rural communities; 5) lower-than-average income for the rural population as a whole; 6) skewed population demographics with a relatively higher percent of people age 65 and greater in communities experiencing a concomitant decline in the young, active working-age population; and, 7) fewer available resources to accomplish the delivery of services at comparable levels to urban areas.

Despite these difficulties, rural America has inherent strengths which make creativity and change more feasible at a time when our health care system needs these attributes. Specifically, rural communities possess an established interdependence and cohesiveness in attempts to resolve problems. These characteristics allow for greater mutuality in identifying barriers to sustaining services and programs related to health care. Rural people have greater access to local resources and are better able to facilitate communication between the six identified critical sectors of the community, including: the dominant economic force, education, commerce, health, religion, and government.

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1 Popper, Frank J. "The Strange Cast of the Contemporary American Frontier." Yale Review. Autumn, 1986. pp. 101-121.

I highlight the relative strengths and weaknesses of rural areas as a way of demarcating the distinct differences from characteristics common to urban America. One of four Americans, one in three elderly, and about one-half of the nation's poor reside in rural America as defined by the Bureau of the Census. Although these groups do not represent a majority, they clearly represent a sizeable proportion of the population whose interests are often neglected and forgotten in policy deliberations and decisions.

Those of us from rural areas have come to expect indifference from the vast bureaucracy relative to the problems and concerns particular to rural America. It is of some comfort that in recent years our policy makers have come to not only appreciate -- but also advocate -- the specific concerns of rural America. The concern expressed by the U.S. Congress in the last two years on rural health must be extended.

Rural health is but one symptomatic element of the overall situation facing rural America. We desperately need a national rural policy. As I have examined the rural health issue over the last decade, I have become increasingly cognizant of the fact that rural health and the health of rural America are inextricably intertwined. Nowhere are these issues more obvious than when we begin a discussion of the rural poor and uninsured which is the focus of my comments today.

There are any number of issues which could be discussed today related to health care in rural America. In previous testimony before the United States Senate Finance Committee and Aging Committee I have highlighted the significant problems associated with reimbursement policy for hospitals and physicians. ([2]) ([3]) ([4]) Rather than once again highlighting these issues, I strongly encourage the Commission and its staff to review and consider the ideas expressed in those documents. I would like to address some other -- equally important -- issues that are too often neglected in our policy deliberations, namely, those of the rural poor and uninsured.

A growing number of Americans are without health care insurance. In 1986 the uninsured included 37 million people, a substantial growth from the 29 million

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2 Fickenscher, Kevin. "Perspectives on Health Manpower Issues Facing Rural America in the Coming Decade." Statement before the U. S. Senate Select Committee on Aging, Washington, D.C., July 11, 1988.

3 Fickenscher, Kevin. "Rural Considerations in Medicare Reimbursement Policy for Physician Services". Statement before the Subcommittee on Health of the U. S. Senate Finance Committee, Washington, D.C., December 6, 1985.

4 Fickenscher, Kevin. "Proposals to Enhance the Viability of Rural Hospitals" Statement before the Subcommittee on Health of the U. S. Senate Finance Committee, Washington, D.C., May 9, 1986.

people in 1980 and 35 million people in 1984. ([5]) More recent data released by the National Center for Health Services Research and Health Care Technology Assessment of the U. S. Department of Health and Human Services for 1987 reveals that the problem has not abated. We continue to have 15.5 percent of the nation's population without insurance.

Of the uninsured, about 25% reside in rural areas or about 8.6 million people of which over one-half have incomes below the 150 percent federal poverty level. A major problem exists, however, in adequately characterizing this population. Little research has been conducted that examines the impact of rural residence with poverty and lack of insurance. As a result, it is often difficult to provide a good picture of the situation in rural America. However, certain facts are known, including:

- over one-third of rural residents are uninsured while 29 percent of urban people are uninsured.

- 43 percent of poor, central city people have Medicaid coverage compared to only 25 percent of poor, rural people.

- privately insured rural residents are less likely to have employer insurance coverage than their urban counterparts and non-employment coverage which is obtained through private plans is less comprehensive that group coverage. As we would anticipate, the gap in uninsured status is greatest for those people with the lowest income levels. ([6])

Several factors seem be contributing to the higher level of uninsured residing in rural America. First, the higher proportion of the rural population without insurance in part reflects the higher degree of poverty in rural America. Second, rural people are more likely to be employed by economic sectors that, as a general rule, do not provide health insurance (e.g. agriculture, small business, lumbering, etc.). Third, states with the highest percent of rural-to-urban population tend to have less extensive Medicaid coverage. Fourth, two parent families are excluded from Medicaid coverage in most states and this particular group is vastly over-represented among the uninsured and poor in rural America.

One of the best papers on the topic of rural poor and uninsured was presented by Rowland and Lyons at the 1987 Rural Health Services Research Agenda Conference. ([7]) I would strongly encourage the Commission to review the document for additional information on this most important topic.

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5 Sulvetta, M. and Swartz, K., The Uninsured and Uncompensated Care: A Chartbook. National Health Policy Forum, Washington, D.C., June, 1986.

6 Farley, P. "Who are the Underinsured?" Milbank Memorial Fund Quarterly, Vol. 63., Number 3, 1985, p. 476-503.

7 Rowland, D. and Lyons, B., "Triple Jeopardy: Rural, Poor and Uninsured". Presented at the Rural Health Services Research Agenda Conference, San Diego, California, December 13, 1987.

Poverty in rural America is a significant problem. As a society we too often think that poverty is someplace else. It's off in the cities or in the Third World. But it's not...it's right here in rural America. Table I provides a comparison of rural versus urban areas based on data from the Bureau of the Census in 1980. Although we are nearly one decade out from that data, little has changed. In fact, Rowland and Lyons conclude that the problem may, in fact, be increasing:

> "The population in rural areas has actually declined from 63.4 million people in 1980 to 52.5 million in 1987. Over the same period, the proportion of the rural population living in poverty has increased from 15 to 18 percent (CBO, 1987). Thus, the shrinking population in rural areas is becoming increasingly poor." ([8])

In profiling the poor and uninsured, the following results are obvious:

- about 13 million of the 33 million Americans under age 65 living in poverty in 1984 resided in rural areas, or about 40 percent of all the poor.

- a disproportionate number of rural compared to urban people are impoverished. One of every five rural people are poor versus one of every seven people for urban areas.

- certain areas of rural America are disproportionately over-represented among the poor. The North Central (27.6%) and South (49.2%) have more impoverished people relative to the total rural population that other sections of the country. This would appear to be an even more important issue during the past two years when our agricultural community has suffered substantially due to drought in both the South and the North Central states.

- Blacks in rural areas are especially hard hit with 46 percent below the poverty level.

TABLE I
A COMPARISON OF POVERTY AND UNEMPLOYMENT
IN RURAL AND URBAN AREAS

	Rural	Urban
Poverty Rate	18.3%	13.8%
Unemployment Rate	8.0%	6.8%
Poor Families with 2 or more Workers	28.9%	15.4%
Underemployment Rate	18.1%	12.3%

8 Rowland, D., and Lyons, B., Ibid.

- o one fourth of rural children under the age of 17 are poor.

- o 21 percent of women residing in rural areas are impoverished although the highest poverty rates are for women in central city areas with 23 percent.

The rural poor are caught in an ever downward spiral. Too frequently, poverty results in poor nutrition, which leads to increasing health problems, which results in higher unemployment, that increases the likelihood of being unable to purchase health insurance, that results in deferring access to health care services despite obvious needs, which increases health problems. We must not underestimate the inability of the rural poor to get out of this downward health spiral once it begins.

Based on the above overview on the role poverty and the status of the uninsured in rural America, there are several policy options which I would encourage the United States Bipartisan Commission on Comprehensive Health Care to consider. Before outlining those recommendations, however, I believe there are a set of inherent principles which should be considered by the Commission as it debates various policy options over the next several months. These principles include:

1. we should invest our national resources in primary and preventive care in order to accomplish the greatest good for the greatest number and insure a good investment in health care by the nation.

2. consumer participation in paying a portion of the cost of services through the use of a required co-payment approach is essential for maintaining consumer interest and involvement in their health care.

3. adoption of a case manager approach to the delivery of health care services for both acute and chronic problems will result in savings not currently possible under the present health care system.

4. a comprehensive, ongoing dialogue which includes representation of government, consumers, business, providers and the insurance industry is essential if progress is to be made in developing a comprehensive health care system.

5. integration of health care services at the community level is an important goal of any changes in our nation's health care system.

6. incentives work better than mandates which is obvious from the significant changes we have seen in care of the elderly as a direct result of the Medicare Prospective Payment System.

7. finally, although the attention of the Commission is primarily directed at health care, I believe, we must recognize that the origin of many of the health care delivery problems in rural areas emanate from non-health issues.

In view of these parameters, I offer a number of suggestions that relate to the efforts of the Commission examine shortcomings in the current health care delivery system and its financing mechanism which limit or prevent access of all individuals to comprehensive health care. These suggestions include:

I. <u>First, and foremost, we need a comprehensive rural development strategy for the nation which recognizes the unique elements for sustaining services in rural America</u>.

Without considering the broader implications of rural development, I do not believe that we can truly address the problems inherent to health care delivery in rural America. Rapid economic change is the cornerstone of the world and we should strive to assist the rural areas of the nation in adapting to that change. Such support is crucial to sustaining a whole host of services such as quality education, good government and accessible health care. ([9]) If we fail in such an endeavor the societal cost will be considerable. Continued outmigration of people from rural areas can be anticipated, erosion of the tax base of rural communities will result, professionals such as teachers, technically trained people and doctors will not consider residing in rural areas, and dismantling of the rural infrastructure can be anticipated. Part of the answer for enhancing health care for the rural poor and uninsured, therefore, revolves around enhancing the rural economic infrastructure. We cannot keep hospitals open, physicians in practice or public health services available if no jobs are present, the tax base erodes and people continue to outmigrate. It is a complex problem which deserves your attention.

II. <u>Adequate reimbursement for services provided by rural hospitals, physicians and other health care providers is an essential component of any strategy designed to sustain health care services in rural America.</u>

Many different legislative proposals have been presented in recent months related to "rural health". The underpinning of these proposals is that we need to have a degree of equity in our health care system. Without equity, we cannot expect to sustain the needed health care services for rural people. In previous testimony before the United States Senate and House, I have provided specific suggestions related to these concerns. I strongly encourage the Commission to consider these suggestions during deliberations in the coming months. If we do keep our rural hospitals alive, if we are unable to recruit and retrain physicians to rural areas because of inadequate payment, if we do not recognize that rural health care facilities compete on a regional and national basis for most of the professionals providing services in rural America; then the health care system will continue to erode substantially over the next several years.

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9 Duncan, C.M., and Tickamyer, A.R., "The Rural Poor: What We Know and What We Need to Know". <u>Northwest Report: A Newsletter of the Northwest Area Foundation</u>. Number 7, March, 1989.

III. Restructuring of the Medicaid program with established national standards is essential if our nation intends to extend equivalent services to all impoverished people regardless of their geographic residence. To accomplish this objective a standard benefit package which includes a minimum floor of services should be federally mandated.

The current Medicaid system allows for too great of variability in standards for eligibility. The end result of an incoherent program is that too few people are eligible for needed services of the Medicaid despite obvious health care needs. In particular, we need to establish a minimum floor for all participating states in the program so that the current disparity is abolished. Under the present circumstances the rural states are too often those where services are limited and eligibility criteria steep. As part of the restructuring effort we must also recognize that certain population groups such as two worker families (more common to rural areas) are inherently discriminated against.

IV. Consideration should be given to legislation that would create a state-coordinated risk pool program that could provide an optional method for the uninsured and the self-employed to purchase an adequate health care insurance package.

One of the major problems in rural areas is that employer-related health insurance programs often are not applicable since the rural people are self-employed. A state-coordinated risk pool program -- while not addressing all people who are uninsured -- will provide a mechanism for a large pool of eligible uninsured to obtain coverage at a reasonable rate. There are potential technical problems such as adverse selection which need to be considered in the development of such a program. However, these technical obstacles should not deter the development of the proposed risk pools. Finally, consideration should be given to providing the self-employed with a tax deduction for the purchase of health coverage. Large corporations are able to deduct the expense of such benefits through provisions in the tax code. The provision of a similar allowance for the small, self-employed individual seems a reasonable approach for encouraging greater coverage of the uninsured population that have sufficient resources to purchase adequate health care benefits.

In sum, there are a number of areas where the United States Bipartisan Commission on Comprehensive Health Care must consider the unique needs of rural America. During the last several years rural health has received increasing attention as an important concern of the United States Congress through the formation of the United States Senate Rural Health Caucus and the United States House Rural Health Coalition. The added voice of the Commission to the ongoing debate on the future of our health care system that considers the rural perspective will be an important contribution during the coming year. Thank you for considering the rural perspective as you develop an agenda for health care in the nation.

Chairman DURENBERGER. OK. Thank you, Kevin, very much. [Applause.]

Now our next witness will be Luanne Nyberg of Minnesota Children's Defense Fund.

STATEMENT OF LUANNE NYBERG, DIRECTOR, MINNESOTA CHILDREN'S DEFENSE FUND

Ms. NYBERG. Thank you, Senator Durenberger. And thanks very much for allowing us to speak today.

I have got a prepared written statement which is much more lengthy than the one I will deliver. And that statement documents and details some of the things that you have already heard about, that children are overrepresented among the uninsured, that there are very poor outcomes. For example, infant mortality in this State has begun to creep up for the last 2 years after decades of decline, which is a very disturbing thing. We also see, for example, preventable diseases like whooping cough creeping up in the eighties in Minnesota after declining for decades. So that the bad things that come when we don't do that preventive care, we now see. They are here. They are happening now.

And the thing I really want to say is I am wondering how to move us past the discussion stage. You have been involved in these discussions for 15 years or longer. The Children's Defense Fund has been. Most of us in this room have been dealing with these questions in one form or another, having grown up in this society which has not yet made this decision for universal access, for a long time. And I am sort of feeling today like maybe we have been too nice. You know, we have said things in a little too professional a way.

And so I was thinking as I drove over here about how to characterize what's going on in our country. And I think these are the two words that characterize them. The first one is "wrong," and the second one is "stupid." [Applause.]

This may sound strong, maybe too strong, but I don't think it is. People accuse the South Africa apartheid. They say that's wrong. That's simply wrong. It's immoral. It's wrong. It's bad. And the people that make those decisions, and by that I don't just mean the government, but the power structure of that country, are immoral. People said that the Holocaust was wrong. But I would submit that the kind of suffering we have heard about here today is just as wrong, absolutely wrong, and it's got to be stopped. [Applause.]

It's also interesting that when you read polls, you find consistently that the American people believe that too. They want action on health care. For people that they believe don't have the wherewithal to buy it themselves, they want the Government to step in and solve this problem, the Government being the collective will of all of us.

I agree with you that employers have to be a major payment source for that because they're a major payment source here. But I do think that we have got to stop letting them off the hook if they feel like being off the hook. We have got to change not only tax treatment but ERISA [Federal Employee Retirement Income Security Act].

We now have a very uneven playing field. We have some employers saying: "Well, I guess I am not going to pay for that." Their competitors are doing it though and then pay the shifted cost. So they get to pay for their own employees plus part of the competitors employees who aren't. We just have a very, very uneven playing field in that area.

On the stupid side, we have already heard about the death, the suffering, the expense, the loss of productivity. You know, these just go on and on. I am not sure that all Americans understand quite the depth of the stupidity, of the kind of neglect, that comes as a result of the neglect of this question of universal access. But I think the people that need to know this know this. I think the health care experts in Government, in health care, policymakers, have come to understand just how silly this nonpolicy is, this nonpolicy of access.

And so what I have been asking myself in the last couple days as I have been trying to prepare this presentation is: What will it take to get us to move from the one end Grace was talking about to the other? How are we going to get off the seat and onto the head and then into action? And I began to think about those Chinese students. I don't think 2 or 3 months ago any of us could have predicted that that would happen. We have been reading that there is sort of a generally improving standard of living in China and, you know, there are lots of Chinese students coming around the world to study. And, you know, it sounded like things were getting slowly better, which is I think what we all would hope for ourselves. And yet something catalyzed there, and there is going to be a change in that country. And I think a change for the better.

What is it going to take? I hope it doesn't take us all racing down into the Government Plaza in downtown Minneapolis or something like that. But I began to wonder. And then I said to myself: "Well, they seem to be ready to do this S&L bailout, and it seems to me that this health care problem is just as big as that." [Applause.]

And I didn't see those S&L managers down demonstrating in any plazas. So I don't know what they did that we haven't yet done. And maybe you could give us some instruction on that.

But it does seem to me that we need something new in this debate, that simply the facts, the figures, the consequences, have not moved the powers that be into action. And that's exactly where we're at. We know there is a problem. We know we can solve that problem.

Certainly the health span proposal that Representative Ogren and many of us worked on discovered that it was a very solvable problem in this State, that for $150 million a year in a financing mechanism beyond what the people themselves could pay we could cover every Minnesotan with what 90 percent of the people ever use. That's not an awful lot of money in a State with a $14 billion biennial budget. And I think the same kinds of numbers are true at the Federal level as well.

So it just seems to me that the question now is how to galvanize ourselves into action. And I think the people in this audience are ready to act, and you need to tell us how to help us move your colleagues into action.

Thank you. [Applause.]

[The prepared statement of Ms. Nyberg follows:]

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Testimony of

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Children's Defense Fund - Minnesota

Before the U.S. Bi-Partisan Commission

on

Comprehensive Health Care

May 25, 1989

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Executive Director

The Children's Defense Fund (CDF) is pleased to have this opportunity to testify before you today regarding uninsuredness and its effects on the health of children. The Children's Defense Fund exists to provide a strong and effective voice for the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of low income and minority children. For more than 15 years, our efforts to improve programs and policies for poor children have included extensive work on the issue of access to health care.

I want to thank you and commend you, Senator, for holding this hearing today to focus attention on one of the major threats to child and family health, lack of adequate health insurance. The erosions in family income, health insurance, and health status have led to an epidemic of uninsuredness. Thus, it is extremely timely for a hearing to be held to review this problem.

In order to appreciate the magnitude of the epidemic of uninsuredness and the barriers to health care services which exist for children and families, we must answer the following questions:

- What is the extent of health insurance coverage for families, particularly children and pregnant women?
- What is the relationship between the insurance status, health care utilization, and health status of children?
- What can be done to improve the health of children?

In the interest of time, I will make my oral comments brief today. However, I would like to submit a complete written statement for the record.

1. WHAT IS THE EXTENT OF HEALTH INSURANCE COVERAGE FOR CHILDREN AND PREGNANT WOMEN?

In recent years, the problem of uninsuredness has been growing. Children are especially likely to be uninsured as a group. As a result of reductions in coverage under employer-based health insurance plans and reductions in federal and state public insurance programs for low-income children, fewer children today have health insurance coverage.

Poor children, whose families generally lack the means to pay for health care expenses "out-of-pocket" are especially likely to be uninsured.

- Between 1980 and 1985, the proportion of children under age 18 covered by employer insurance fell by 6 percent (from 64.6 percent to 60.6 percent. Among poor children under age 18, the proportion privately covered declined by one-quarter, from 16.9 percent to 12.8 percent. [1]

- In 1986, nearly one out of every 5 children in families -- over 11 million nationwide--had no health insurance, public or private. (Table 1)

- By 1986 nearly one third of all poor children were completely uninsured. This translates into 4 million poor children nationwide. While an estimated 1.5 million children have been added to the Medicaid program since 1986, the remaining 2.5 million lack the key to access to health care--insurance.

- In 1986, more than 4 out of every 10 children in employed poor families had no health insurance public or private. These children have traditionally been left outside of the scope of the Medicaid program and, increasingly, their families lack employer based dependent coverage. (Table 2)

The absence of health insurance, public or private, is most clearly seen in low income working families. These children are less likely to have access to employer-based family coverage, and yet nonetheless are unlikely to be eligible for Medicaid. Many children in such families could be classified as "near-poor"

(with family incomes between 100 and 200 percent of the federal poverty level).

- In 1986, nearly 3 out of 10 children in near-poor families had no health insurance. (Table 2A)
- In that year, just over half of near-poor children had private, employer-based health insurance coverage. Moreover, among this group, the full cost of the children's premiums was covered by the employer or union in only 32 percent of the cases.

The best way to ensure that a baby will be born healthy, is to ensure the health of the mother during pregnancy through prenatal care. Women of childbearing age need access to health care, especially during a pregnancy. Yet inadequate health insurance coverage acts as a barrier to health care for women.

- Among women of childbearing age (15-44 years), 9.5 million had no health insurance, public or private, in 1985. If women who have some health insurance but lack adequate maternity care coverage were included then over 14 million women were completely unprotected against the cost of maternity care in 1985. [2]

While recent federal changes in Medicaid ensure coverage of all poor women beginning in 1990, millions of near-poor women continue to be uninsured or underinsured. These women, young, married, in a employed family with an annual income of just under $20,000, are most typical of those who give birth today.

2. WHAT IS THE RELATIONSHIP BETWEEN INSURANCE STATUS, HEALTH CARE UTILIZATION, AND HEALTH STATUS?

Studies have shown that health insurance is a significant determinant of health care utilization. The uninsured use substantially fewer services than their insured counterparts, even when health status and the need for services is taken into account.[3] Research also has shown that even among the poorest

families, health care coverage can bring health care utilization up to average levels. [4]

- o National survey data reveal that low-income uninsured children have a lower likelihood of, and a significantly lower average of, visits to physicians. When adjusted for health status, uninsured children remain most likely to have no physician visits in a year. [5]

- o Even among children with identified disabilities who participate in special education programs, lack of health insurance has been found to be associated with reduced access to necessary health care. [6]

- o However, poor children with Medicaid coverage are far more likely than their uninsured counterparts to have a regular source of health care and to visit a physician in a year. Medicaid recipient children use services in a pattern similar to that of their affluent, privately insured counterparts. [7]

- o Uninsured low income women are less likely to receive care early in pregnancy and are twice as likely to receive late or no prenatal care. [8]

Adequate access to health care is critical to maternal and child health and saves money by preventing unnecessary illness, disability, and death.

Maternity care, beginning with prenatal care in the critical first three months of pregnancy and continuing through the birth of a child, can dramatically improve maternal and infant health. An infant born to a woman receiving no prenatal care is more than 3 times more likely to die in the first year of life. Prenatal care can save $3 for every $1 invested. [9] Yet each year, millions of infants are born to women who did not receive early care.

- o In 1986, 20 percent of women in Minnesota did not receive prenatal care in the first three months of pregnancy. Among nonwhite women, 44 percent did not receive early care.

- o In that year, nearly one in four babies nationwide were born to a mother who did not benefit from early care. (Table 4)

The Institute of Medicine of the National Academy of

Sciences reports that "financial barriers--particularly inadequate or nor insurance and limited personal funds--were the most important obstacles reported in 15 studies of women who received insufficient care."[10] From New York City to Oklahoma City, these studies document the financial barriers which keep women from receiving early and adequate prenatal care.

Immunizations, beginning in the first months of life, can eliminate the death and disability that can result from now-preventable, childhood diseases such as measles, mumps, pertussis (whooping cough), diphtheria, tetanus, polio, and meningitis. Childhood immunizations save $10 for every $1 invested. Yet between 1980 and 1985, immunization levels for our nation's infants and toddlers eroded significantly.[11] Inadequate immunization levels lead to outbreaks of preventable disease.

- The Minnesota Department of Health reports that pertussis (whooping cough) is more prevelant in the 1980's than it was in the 1970's. This parallels increased child poverty and uninsuredness trends in Minnesota. (Figure 1)

- Nationwide in 1987, there were over 2,800 reported cases of pertussis, with nearly half occurring among infants. In that year, there were over 1,000 cases of measles and over 800 cases of mumps among preschool age children (younger than age 5).[13] (Figure 2)

Comprehensive primary and preventive care for children can detect and treat a wide range of health conditions before they become serious. Screening for lead poisoning, learning disabilities, vision impairments, and dental health needs can reduce the consequences of these health problems. Children who receive comprehensive primary health care have annual health costs 7 to 10 percent lower than those who do not. However, many children do not receive such preventive care.

- In 1986, as a result of inadequate access to health care, poor children were considerably more likely than affluent children to have had a routine physical in the previous year.[14]

- National surveys indicate that poor children are at least 3 times more likely than affluent children to have never had a physician visit (5.4 percent and 1.6 percent, respectively).[15]

3. WHAT CAN BE DONE TO IMPROVE CHILDREN HEALTH AND HEALTH INSURANCE STATUS?

We understand how to keep most children healthy. We know that every child needs health care. Good medical care begins before a child's birth with comprehensive prenatal care. It continues throughout childhood, with care for a child's preventive, acute, and chronic health care needs.

No child--whether the need is for immunization, treatment for a strep throat, dental care, hospitalization, medicines, or eyeglasses--should go without health care because a family cannot afford it. No pregnant woman should be denied prenatal care because she does not have enough money to pay for it.

The current gaps in insurance coverage and medical care among children are costly in both human and fiscal terms. While maternity and pediatric services have been found not only to be effective, but they have been shown to be a remarkably cost-effective type of health care investment. Our highly sophisticated medical system can offer preventive or remedial care for most child health problems. Yet a series of events have left our children vulnerable to preventable childhood disease, disability, and death.

Medical indigency not only creates an extremely serious threat to the health of low income children and families, but it also poses a substantial threat to the health care system that

cares for low income families. Many public and community clinics and institutions treating the poor are under serious financial stress, chiefly because of the combined effects of the large medically indigent population they treat and shortfalls among various public and private payers for their insured patients.

Thus, there are two basic approaches to dealing with the problem. Neither is exclusive. First, we need to improve public and private health insurance programs in order to generate a health care financing system that insures individuals for basic services. In the case of children and pregnant women, the cost of insurance reforms may be particularly modest in comparison to the longterm costs associated with failure to make such reforms. Second, direct subsidies to public and community institutions providing a large volume of care for the uninsured are needed, in order to promote targeted improvements and services.

A. Recent Improvements in Maternal and Child Health Programs

In recent years, Congress has taken steps to improve access to health care for pregnant women, infants, and children. These include changes in key maternal and child health programs such as Medicaid, the Maternal and Child Health Block Grant, Community and Migrant Health Centers, and childhood immunization programs.

Medicaid: The Medicaid program is the primary health care financing program for low income children and pregnant women. In 1987, more that 11.6 million children under age 18 received services paid for by Medicaid. Medicaid paid for maternity care for approximately one-half million births that year.

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Since 1984, in an effort to improve maternal and child health among low income families, Congress has enacted a series of Medicaid improvements. (Figure 3) As a result, by 1990 all pregnant women and infants with family incomes below 100 percent of the federal poverty level ($9690 per year for a family of three in 1988) will be covered by Medicaid, and several states will have extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (roughly $18,000 per year for a family of three).

In addition, 30 states have used the option to extend coverage to some of the youngest children with family incomes below the poverty level. However, millions of poor children nationwide remain uncovered.

If all states extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (nine already do so), then Medicaid will be available to cover health care costs for nearly one out of two births in the United States. If coverage were extended to all children with family incomes below the federal poverty level, Medicaid would become a source of health care financing for one in five American children.[16] A substantial proportion of these families currently have no source of health care coverage, public or private.

Title V Maternal and Child Health Block Grant: For over fifty years, the Title V Maternal and CHild Health programs have served our nation's mothers and children. Title V programs provide prenatal care to hundreds of thousands of low income and

medically indigent pregnant women. Millions of children receive basic preventive health care and treatment for minor illnesses, as well as specialized health services for chronic illnesses and disabilities.

Since Fiscal Year 1987, a portion of any newly appropriated funds are earmarked for child health demonstration projects.

Community and Migrant Health Centers: The nearly 600 community and migrant health centers are comprehensive primary health clinics funded by the federal government and located in some of the most medically underserved communities in the United States. Health Centers serve nearly 6 million low income patients annually. In 1986, more than one-third of patients were children under age 14 and one in four was a woman of childbearing age. About 10 percent of all low income births nationally were to health center patients that year.

For Fiscal Years 1988 and 1989, Congress added a funding supplement to the health centers programs for infant mortality reduction services. (Basic funding levels are set at $415 million for community health centers and $45 million for migrant health centers.) The current $20 million funding level for this supplement is adequate to fund only a little over one-third of existing health centers, and even these clinics have received only about half of the amount that they needed to expand and strengthen their service capacity.

Childhood Immunization The federal childhood immunization program is the main source of public support for the nation's efforts to reduce preventable childhood disease. Through the program, grants are provided to allow state and local health

agencies to purchase vaccines for millions of American children. The program also provides basic funding for the infrastructure of our national vaccine system (e.g., storage and preservation of vaccines in an emergency stockpile, centralized surveillance, and outbreak control activities).

For Fiscal Year 1989, Congress appropriated an additional $40 million for the vaccine program activities. However, following a decade of spiraling vaccine price inflation and eroding childhood immunization levels, additional funds are needed to bolster this critical system.

Health Manpower Programs: A health manpower crisis for poor and rural communities looms on the horizon. In 1981, Congress, at the urging of the Reagan administration, began a phase-out of the National Health Service Corps scholarship program. By 1988 only 40 scholarships were awarded, compared to over 4,300 in 1980. As fewer scholarships are awarded, the service pipeline in-turn will run dry.

The health manpower programs which were reauthorized by Congress in 1988 to provide scholarship and loan assistance to medical, nursing and health professions students and graduates will make a small dent in this problem. However, the nation now has over 1,900 primary care health manpower shortage areas, affecting nearly 13 million people.

B. **What Issues Await Further Action?**

If the nation is to make real progress in reducing infant and childhood death and disability, then the reform efforts undertaken since the mid-1980's must be expanded and

strengthened. The following expenditures represent a basic level of investment in the health of America's children.

1. Congress and the states must act to further reduce uninsuredness among near-poor pregnant women and poor and near-poor children.

- New federal mandates for Medicaid coverage of these groups should be phased-in over the next few years. Medicaid coverage should be provided to all pregnant women and children with family income below 200 percent of the federal poverty level. Federal outlays of approximately $120 million over the next three years would be needed to begin the phase-in.

- The Medicaid programs should be expanded to cover all poor children. The federal share of this expansion would be approximately $200 million over the next three years. Coverage for near-poor children should be phased-in in future years.

- In addition, states should be given the authority now to improve their Medicaid programs in a number of ways. For example, policies which allow states to guarantee annual enrollment periods for children, eliminate resource tests, and conduct aggressive outreach programs are important steps in ensuring that Medicaid-eligible children and pregnant women enroll in the program early and receive the preventive and primary health care they need. These are low cost initiatives which make federal and states eligibility expansions meaningful at the local community level.

2. Congress should expand access to care through enhancements to publicly-funded health programs.

- Funding for the Community and Migrant Health Centers should be expanded so that clinics can be developed in all medically underserved areas and maternity and infant services can be expanded and strengthened in all clinics. An additional $47 million is needed in Fiscal Year 1990 for the maternity and infant care initiative.

- The Title V Maternal and Child Health Block Grant should be expanded to permit states to better develop comprehensive maternity and child health services in underserved areas. An investment of an additional $100 million would permit nearly all states to develop statewide networks of providers.

- Funding levels for the childhood immunization program must remain adequate to ensure purchase of the necessary level of public sector vaccine, a system for providing families with information about the availability and safety of vaccines, and generally to support a national childhood vaccine

system. An additional $35 million is needed in Fiscal Year 1990 to protect all of our children against preventable childhood disease.

- Health manpower programs which designed to provide scholarship and loan assistance to medical, nursing, and health professions students and graduates working in manpower shortage areas should be fully funded in Fiscal 1990. Full funding for these programs would cost approximately $162 million.

3. Congress should enact Healthspan nationwide. Only a comprehensive, insurance based, publicly /privately funded program that covers all Americans no matter what their income, employment or family status will really solve the uninsuredness problem.

- Healthspan is an eminently affordable, workable approach to insuring the uninsured.
- By shifting the mandate from the employer to the individual (much as we mandate auto insurance for car owners), Healthspan ensures that coverage will continue no matter what the individual's circumstances.
- The proposed Healthspan sliding fee payment structures ensures that low income people will be able to afford to fulfill their insurance responsibilities.

CONCLUSION

The question is not whether the nation can afford these reforms but whether the nation can afford not to enact them. Our recommendations have a Fiscal Year 1990 price tag of approximately $3.5 billion. The first year costs alone of caring for infants born too soon and too small whose condition could have been prevented if the nation had made sufficient progress to meet the Surgeon Generals 1990 Health Objective will exceed $6 billion by the year 2000. The cost of the reforms CDF recommends is very small compared to the cost of lifetimes of treatment and lost earnings for children whose disabilities could have been prevented. These expenditures represent such a basic level of investment in the health and safety of all of our children that their enactment cannot be further delayed.

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Table 4 Insurance Status of Children Younger than 18 in Families, by Income[1], Race, and Insurance Status, U.S., 1986

Income as a percent of poverty	All Races			White			Black		
	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	H.
Children in Families (in thousands)	12,715	26,355	62,745	8,070	18,836	50,934	4,129	6,560	9,1
Percentage of insured children by type of coverage[2]									
Medicaid alone or with other coverage	52.3%	30.3%	13.4%	47.2%	25.2%	9.9%	61.6%	43.8%	31.
Medicaid only	48.3%	26.8%	11.7%	42.9%	21.7%	8.4%	59.0%	40.7%	28.
Employer coverage	11.5%	33.6%	61.4%	13.4%	37.3%	65.9%	7.9%	23.6%	33.
VA, CHAMPUS, military[3]	2.2%	3.6%	3.5%	2.7%	4.3%	3.8%	--	1.4%	4.
Other health insurance	6.0%	7.1%	7.6%	7.7%	8.2%	8.2%	--	2.5%	4.
Percentage of children insured	67.6%	69.6%	81.1%	66.3%	69.6%	82.5%	69.9%	69.1%	73.
Percentage of children uninsured	32.4%	30.4%	18.9%	33.7%	30.4%	17.5%	30.1%	30.9%	26.

[1] Income measured as a percentage of the federal poverty level.

[2] Percentages may not equal 100 percent because some children have insurance from more than one source.

[3] The U.S. Department of Defense covers health care for members of the military and their dependents, including children, at militar institutions and at civilian facilities.

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund.

Table 2. Percentage of Children in Families with Employer-Based Coverage with All Premiums Paid by Employer or Union, by Income[1], Age, and Race, U.S., 1986

Income Level	Total Number of Children With Employer-Based Coverage (in thousands) Less Than 100%	Less Than 200%	Less Than 400%	All	Percentage of Children with All Coverage Costs Paid by Employer or Union Less Than 100%	Less Than 200%	Less Than 400%	All
All races								
Under age 6	593	3,345	9,571	13,125	28.2%	31.0%	34.8%	37.5%
Ages 6-17	863	5,303	17,610	25,415	25.8%	31.6%	36.1%	38.4%
Total	1,456	8,648	27,181	38,540	27.3%	31.5%	35.7%	38.2%
White								
Under age 6	468	2,773	8,330	11,533	29.7%	31.9%	35.9%	38.6%
Ages 6-17	611	4,256	14,925	22,018	33.4%	35.0%	37.7%	39.7%
Total	1,079	7,029	23,255	33,551	31.8%	33.8%	37.0%	39.4%
Black								
Under age 6	106	479	990	1,177	--	25.5%	26.3%	27.8%
Ages 6-17	221	1,067	2,166	2,567	--	20.2%	26.0%	27.6%
Total	327	1,546	3,156	3,744	--	21.5%	26.1%	27.6%

[1] Income measured as a percentage of the federal poverty level.

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund.

TABLE 20. CHILDREN AGE 0-17 YEARSIN FAMILIES BY INCOME, RACE, AND INSURANCE STATUS, 1986

		ALL RACES (numbers in thousands)				WHITE (numbers in thousands)				BLACK (numbers in thousands)			
		(100%	100-200	(200%	ALL	(100%	100-200	(200%	ALL	(100%	100-200	(200%	ALL
ALL CHILDREN	(number)	12,715	13,640	26,355	62,745	8,070	10,766	18,836	50,934	4,129	2,431	6,560	9,606
INSURED CHILDREN BY TYPE OF COVERAGE													
WITH MEDICAID	(number)	6,647	1,351	7,998	8,438	3,808	945	4,753	5,045	2,545	330	2,875	3,013
	(percent of total)	52.3%	9.9%	30.3%	13.4%	47.2%	8.8%	25.2%	9.9%	61.6%	13.6%	43.8%	31.4%
WITH MEDICAID ONLY	(number)	6,145	928	7,073	7,332	3,462	632	4,094	4,260	2,437	230	2,667	2,754
	(percent of total)	48.3%	6.8%	26.8%	11.7%	42.9%	5.9%	21.7%	8.4%	59.0%	9.5%	40.7%	28.7%
WITH EMPLOYER COVERAGE	(number)	1,456	7,392	8,848	38,540	1,079	5,950	7,029	33,551	327	1,219	1,546	3,744
	(percent of total)	11.5%	54.2%	33.6%	61.4%	13.4%	55.3%	37.3%	65.9%	7.9%	50.1%	23.6%	39.0%
WITH VA, CHAMPUS, MILITARY	(number)	274	724	998	2,424	216	589	805	1,916			94	394
	(percent of total)	2.2%	5.3%	3.8%	3.9%	2.7%	5.5%	4.3%	3.8%			1.4%	4.1%
WITH OTHER HEALTH INSURANCE	(number	760	1,118	1,878	4,794	625	922	1,547	4,187			189	422
	(percent of total)	6.0%	8.2%	7.1%	7.6%	7.7%	8.6%	8.2%	8.2%			2.9%	4.4%
TOTAL CHILDREN INSURED	(number)	8,600	9,731	18.331	50,882	5.350	7,762	13,112	42,030	2,887	1,643	4,530	7,067
	(percent of total)	67.6%	71.3%	69.6%	81.1%	66.3%	72.1%	69.6%	82.5%	69.9%	67.6%	69.1%	73.6%
TOTAL CHILDREN UNCOVERED	(number)	4,115	3,909	8,024	11,863	2.720	3,004	5,724	8,904	1,242	788	2,030	2,539
	(percent of total)	32.4%	28.7%	30.4%	18.9%	33.7%	27.9%	30.4%	17.5%	30.1%	32.4%	30.9%	26.4%

Table Percentage of Infants and Toddlers Who Were Fully Immunized[1], by Age and Race, U.S.[2], 1980 and 1985

Infants

		Polio	DTP[3]	Measles	Mumps	Rubella
Total	1980	80.0	84.2			
	1985	79.6	82.7	These vaccines are not recommended for children of this age.		
White	1980	80.9	84.9			
	1985	81.5	84.4			
Nonwhite	1980	73.2	79.0			
	1985	58.5	64.8			

Age one

		Polio	DTP	Measles	Mumps	Rubella
Total	1980	95.5	76.2			
	1985	95.2	78.3	These vaccines are not recommended for children of this age.		
White	1980	96.2	78.6			
	1985	96.9	80.1			
Nonwhite	1980	89.1	56.5			
	1985	82.3	64.9			

Age two

		Polio	DTP	Measles	Rubella	Mumps
Total	1980	80.7	87.0	83.0	83.2	80.2
	1985	76.7	85.8	81.7	77.3	78.9
White	1980	83.0	89.4	84.8	84.4	81.5
	1985	79.5	88.0	82.7	78.6	80.8
Nonwhite	1980	62.8	68.0	69.0	73.4	70.7
	1985	56.5	69.1	74.7	66.9	64.2

[1] Dosage levels are approximations of level needed to fully immunize a child of a given age: younger than age one, one or more doses of polio and DTP; at age one, one or more doses of polio and three or more doses of DTP; and at age two, three or more doses of polio and DTP and one dose of measles, rubella, and mumps vaccines.

[2] Data are from the U.S. Immunization Survey sample confirmed by parent consultation with an immunization record.

[3] DTP stands for a combined dose of diphtheria, tetanus, and pertussis vaccines.

SOURCE: U.S. Immunization Survey, Centers for Disease Control.

Table 4 United States Fact Sheet, 1986

	White	Nonwhite		Total
		Black	Total	
Births				
To all women	2,970,439	621,221	766,108	3,756,547
To women age 19 and under	315,335	141,606	156,746	472,061
To women under age 15	4,007	5,877	6,169	10,176
Teen Births				
As percentage of all births				
To women age 19 and under	10.6%	22.8%	19.9%	12.6%
To women under age 15	0.1%	0.9%	0.8%	0.3%
Low-Birthweight Births				
Percentage of births that were low birthweight:				
To all women	5.6%	12.5%	11.2%	6.6%
To women age 19 and under	7.7%	13.3%	12.7%	9.4%
Percentage of all low-birthweight births:				
To women age 19 and under	14.4%	24.1%	22.6%	17.3%
Prenatal Care				
Percentage of babies born to women who:				
Began prenatal care in the first trimester				
All women	79.2%	61.6%	63.7%	75.9%
Women age 19 and under	55.9%	46.8%	47.1%	53.0%
Began prenatal care in the third trimester or not at all				
All women	5.0%	10.6%	9.9%	6.0%
Women age 19 and under	11.6%	15.0%	15.3%	12.7%
Received adequate prenatal care				
All women	72.6%	50.6%	51.8%	68.4%
Received inadequate prenatal care				
All women	6.3%	15.3%	14.7%	8.0%
Infant Mortality				
Infant deaths per 1,000 live births				
Total infant deaths	8.9	18.0	15.7	10.4
Neonatal deaths	5.8	11.7	10.1	6.7
Postneonatal deaths	3.1	6.3	5.5	3.6

SOURCE: National Center for Health Statistics. Calculations by Children's Defense Fund.

MINNESOTA MORBIDITY AND MORTALITY

Cases and [Deaths] of Reportable Diseases to Acute Disease Programs Section

Figure 1

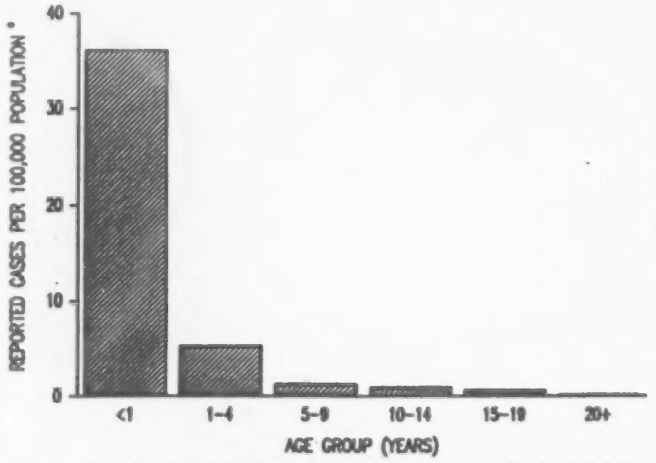
	[redacted]	[redacted]	[redacted]	pertussis	[redacted]	[redacted]	[redacted]	Chlamydia	Gonorrhea	Early Syphilis	Congenital Syphilis	Tuberculos
Year First Reported:	1910	1913	1955	1914	1910	1964	1918	1985	1938	1918	1918	1906
Peak Year and Number of Cases:	1910 5012(500)	1935 29759(66)	1955 2080	1933 5272(77)	1952 3926(206)	1964 3232	1923 40(37)		1975 10042	1947 1654		1916 5280
Year												
1970	0	29	606	5	0	107	2(1)	n/a	4352	111	1	339
1971	1(1)	59	1425	15	0	291	4		6231	116	0	263
1972	0	27	727	11	0	501	1		8567	116	1	277
1973	0	25	109(1)	0	0	224	0		9315	184	1	252
1974	0	05(1)	100	2	0	18	3		9192	151	1	245
1975	0	232	206	3	0	37	2(1)		10042	190	0	194
1976	0	431	251	182	0	36	2		9205	178	0	213
1977	0	2650	40	7	4	27	2		9073	240	2	211
1978	0	46	24	23	0	128	2		8527	250	4	175
1979	0	1219	27	9(1)	1	43	0		8214	152	2	190
1980	0	1104(2)	20	20	0	28	1		7931	224	1	237
1981	0	3	9	16	1	9	2(1)		7248	288	2	168
1982	0	0	455	34(1)	0	7	6		6415	245	1	157
1983	0	1	30	49	0	9	3		5885	291	0	165
1984	0	47	7	16	1*	4	1		6080	197	1	138
1985	0	6	1	140	0	2	1(1)	129	6307	72	0	142
1986	0	50	06	50	0	1	0	2007	5406	67	0	155
1987	[redacted]							5177	4328	42	0	121

*delayed report for 1982

Minnesota Department of Health

FIGURE 2

PERTUSSIS (whooping cough) — By age group, United States, 1987



*Rates were calculated by multiplying the percentage of cases with known age group by total reported cases and dividing by the population in that age group.

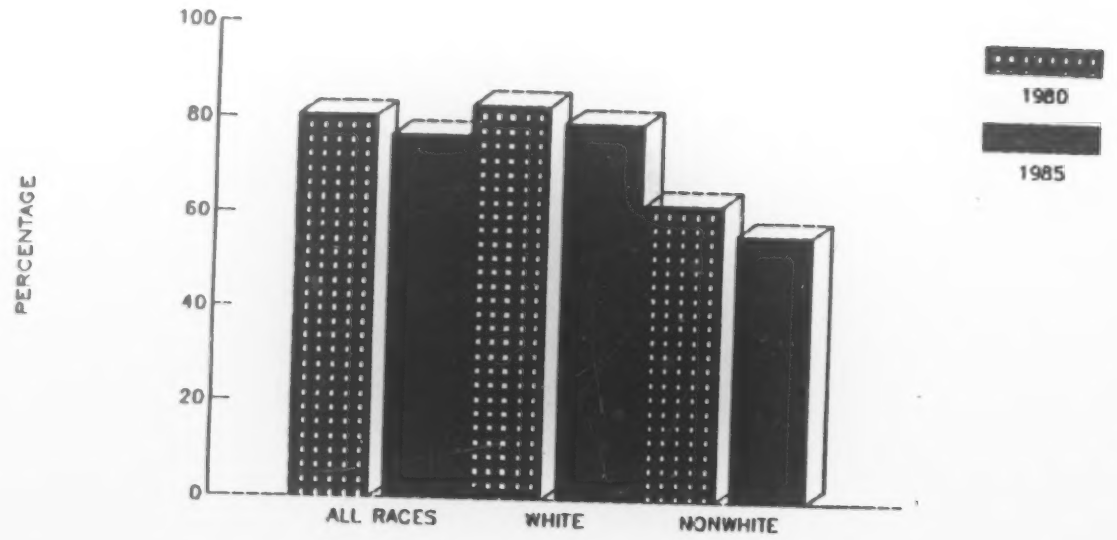
33

SOURCE: CENTERS FOR DISEASE CONTROL

FICURE 3

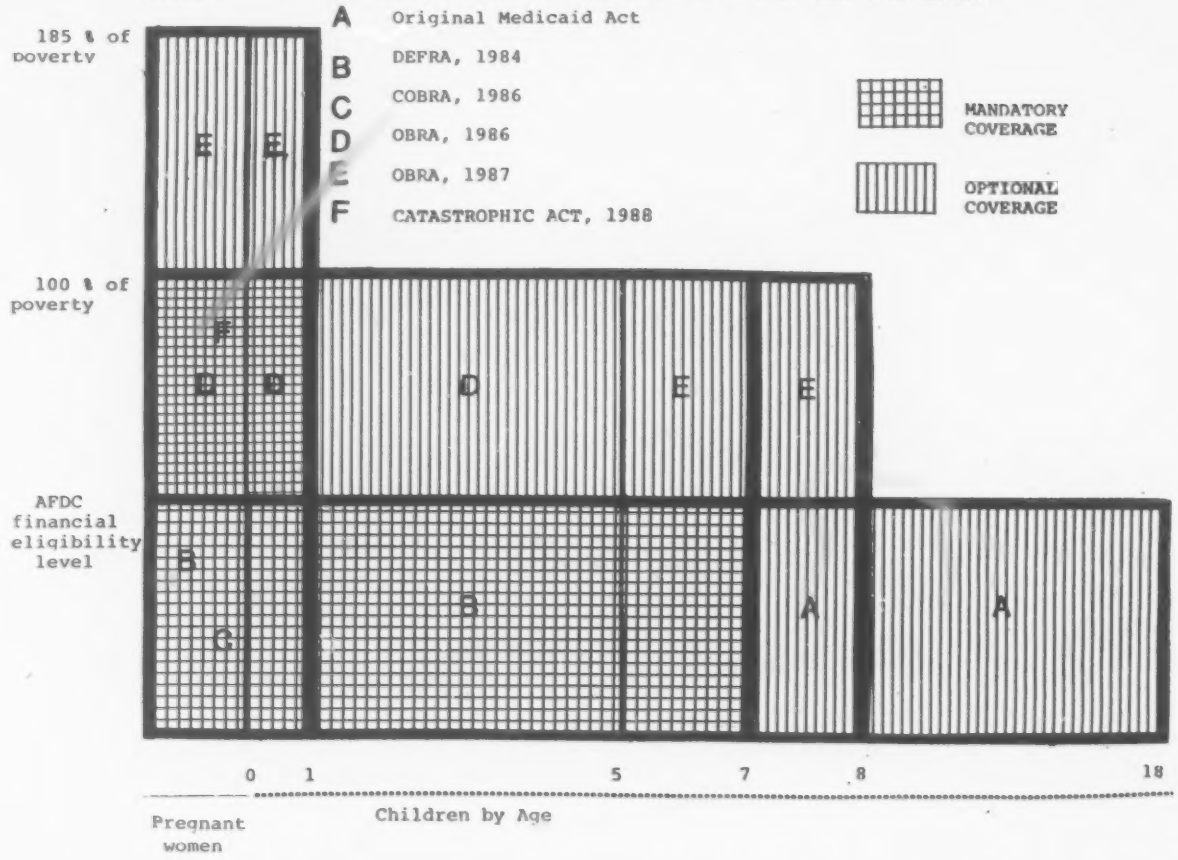
POLIO IMMUNIZATION AMONG TWO--YEAR--OLDS.

BY RACE, U.S., 1980 AND 1985



SOURCE: CHILDREN'S DEFENSE FUND

FIGURE 4 MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN



THESE ARE REAL PEOPLE . . .

400,000 Minnesotans Have No Health Coverage

HERE IS FAMILY STORY #1

Glen and his wife Martha live on a farm on Minnesota's eastern border. They have three kids Dwayne, age 11, Bobby, age 10 and David, age 9. Glen says he has looked at every possible way of cutting back on his family's expenses in order to buy a family health insurance plan.

"I drive 100 miles a day, round trip, to a city job that pays more than anything around here. We raise our own food, the kids wear clothes from the Salvation Army, we rarely buy any nonessential things, and we seldom go out for entertainment. What else can we cut out of our lives?" Glen asks.

Since there's no way to buy health insurance, Glen says his family goes without adequate medical care.

"It would be great if I were the only one in the family who got sick, since I have health insurance through work. But it doesn't work that way."

I get bronchitis, I go to the doctor, take a few pills, and 'presto!' I'm better," Glen says. "But how can I feel good about that when my son Bobby gets bronchitis and just has to tough it out? He gets bronchitis all the time and it would probably go away quicker if he had antibiotics."

The list of Glen's children's untreated medical problems seems longer than his trip to the city every day. Respiratory infections, rashes, severe poison ivy, cuts that needed stitches, chronic allergies, and chronic bronchitis are just some of the children's problems that the family couldn't afford to treat.

"Don't forget," Glen says, "to tell them about the medical bills we're trying to chip away at: X-rays, broken bones, immunizations, medications..."

To come, story #2: an 11-year-old with multiple health problems who can't get coverage.

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400,000 Minnesotans Have No Health Coverage

HERE IS FAMILY STORY #2

Emily, a self-employed single mother who lives in Minneapolis, can no longer afford the soaring cost of health insurance or health care for her 11-year-old daughter, Rachel.

"I found out a year ago that my daughter is a victim of sexual abuse. We have been going through hell, made worse by medical and psychiatric bills I can't pay. Collection agencies remind me weekly that my daughter was sexually abused and I have to pay for it."

When asked if she had applied for Medical Assistance, Emily answered angrily, "I couldn't possibly live on the income the government allows you to have if you want to receive Medical Assistance. There is no way I can provide decent food, clothing and shelter for my daughter for $582 a month."

Even if Emily could afford health insurance, chances are Rachel's sexual abuse would be considered a preexisting condition and disqualify her.

When we mentioned Minnesota Comphrensive Health Insurance as something she ought to look into, she responded, "I have. Rachel also has asthma -- another preexisting condition. Minnesota Comprehensive Insurance covers preexisting conditions, but only after 60 days. Rachel's asthma certainly won't take a planned vacation and besides, I can't afford that insurance anyway."

How does Rachel manage to continue to receive weekly therapy sessions when her mother can't afford to pay?

I think the mental health clinic where Rachel goes feels sorry for us," Emily says. "I've paid them a little, and they never harass me for the money. But it's a terrible way to live. It's humiliating to work hard and still not be able to pay your bills."

"I really hope," Emily adds, "they do the health insurance plan you told me about. I don't think Rachel should have to suffer because I can't make enough money to pay the high costs of medical care, do you?"

To come, story #3: An Olmsted County family that avoids care and shares drugs because they have no insurance.

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HERE IS FAMILY STORY #3

"The hole in our daughter's heart was the size of a dime," Roger says.

Cheryl, who is now 9, was born with this hole in her heart. When she was five, the doctors sewed it up, and the insurance plan her dad had through work paid for it.

The insurance was also going to pay for the critical yearly checkups, but it is gone now. Cheryl's dad injured his back and is out of work.

The Children's Health Plan, which would cover Cheryl's checkups, is out of reach since it only covers kids through the age of 8.

Cheryl's brother Tommy, age 7, recently got coverage through the Children's Health Plan. "Lucky for us," Joan says, "because Tommy just had out patient surgery for urological problems."

Joan and Roger, already burdened with unpaid medical bills, never saw Tommy's bill. The Children's Health Plan paid for it.

Somehow, even without the Children's Health Plan, this Olmsted County family says they will manage to pay for Cheryl's yearly checkups. Joan, who does child care in their home, says she'll worry about the bills when they are due.

But how do they cope with Cheryl's "normal" illnesses?

"I shouldn't even be telling you this," Joan says. "Because I signed up for health insurance when I first started doing child care, I am able to afford doctor visits and prescriptions for myself. Last week Cheryl had a horrible cough. I was sure it was bronchitis. I called my doctor, whom I know pretty well, and I told him I was sure I had bronchitis. Since he had already seen me several times for bronchitis, he prescribed antibiotics over the phone. I got them and gave them to Cheryl."

Joan is only one of thousands of Minnesota parents who "wheel and deal" to get some sort of health care for their uninsured children.

To come, story #4: A St. Louis Park mother and daughter who wonder if they should go back on welfare so they can get their asthma and ulcer medications.

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THESE ARE REAL PEOPLE . . .

400,000 Minnesotans Have No Health Coverage

HERE IS FAMILY STORY #4

"When my daughter was younger, from birth to five, she had multiple health problems -- ear infections that eventually required tubes in her ears, adnoid problems, perforated ear drums, and bladder difficulties that resulted in surgery. If she had these problems today, I'd be buried. The bills and stress would have killed me."

The only reason Lisa, a single mother who lives in St. Louis Park, wasn't buried by those medical bills was because she was on welfare and Medical Assistance paid for all her daughter Cindy's medical needs.

Today Lisa is off welfare and working. Getting off welfare and supporting her family has been a long sought after goal for Lisa.

"But, I guess supporting myself was too good to be true," Lisa said. "It seems that every time you try to get off welfare, somebody is there to kick you down."

Lisa has checked over 10 HMOs and insurance companies. Not one of them will insure her and her daughter, though her employer agreed to pay for it.

"My daughter and I are filled with what insurance companies call 'preexisting conditions'." Lisa says. "The only insurance we'll be able to get is Minnesota Comprehensive Health Insurance and that isn't going to help me pay for Cindy's asthma and allergy medicine or my ulcer medicine. And, I can't afford MCHI."

Lisa says if the Children's Health Plan were expanded to cover older children, her daughter, who is 11, would qualify. Under the Healthspan proposal, both would get help.

But right now mother and daughter are going without their asthma, allergy, and ulcer prescriptions. "I just don't have the $200 a month it costs," Lisa says.

Lisa says that it's hard for her to see Cindy going without her allergy medicine and that sometimes it's hard for her to work without ulcer medicine.

"You know," she says, "it's no wonder why some women stay on welfare."

To come, story #5: A laid-off St. Paul mother of four makes sacrifices but still can't get her children the care they need.

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THESE ARE REAL PEOPLE . . .

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HERE IS FAMILY STORY #5

A week ago Sally, 15, felt like she couldn't breathe. She lay on the couch waiting for her mom to get home.

"I could tell the minute I walked in door that she was sick," Susan said. "I felt like screaming, 'Why are you sick on a Saturday? Why couldn't you get sick during school so you could go to the school clinic for free?'"

Susan, a single mother of four children, was laid off six months ago from her job at St. Paul hospital where she was making $7.02 an hour and getting some health insurance for herself. Now her family tries to make it on unemployment and the a monthly social security payment for the children.

"Poor Sally, it's not her fault I can't afford health care," Susan says.

What does Susan do to take care of her family's health and the soon-to-follow dreaded bills now that she doesn't have health insurance?

"You know, I tell people that bill collectors don't bother me, that I just send them what I can. But I really feel like screaming, 'Oh, leave me alone. I'm sick to death of your threatening letters.'"

What bothers Susan even more than bill collectors is the fact that her children can't get prompt and consistent medical care from one clinic or doctor.

"My children's medical records are all over the metropolitan area. Sally's just getting over acute strep throat. If I'd been able to take her to a doctor over the weekend instead of waiting for the school clinic to open Monday morning, she probably wouldn't have had such a severe case and would have gotten better sooner and back to school quicker."

"I feel like most doctors think I am too cheap to buy my kids medicine or take them to a doctor. It might not be much to them," she says, "but I don't have it. If they only know the hundreds of dollars I've put out for simple health care or the sacrifices my family has made in order to buy medication or see the doctor."

To come, story #6: This mother took a job specifically so she could get health insurance, but can't afford dependent care at the prices charged her small employer. Her daughter still waits.

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HERE IS FAMILY STORY #6

"I thought getting a full time job with health insurance benefits would be the answer to my prayers. Boy was I wrong."

Julia is a single mother living in Minneapolis. Until just recently, she was self-employed and managed to pay for most of her medical bills by, as she says, "the skin of my teeth."

Then a crisis happened. Julia's 10-year-old daughter, Anna, fell ice skating and fractured a vertebrae. When Anna's medical bills soared, Julia decided she had to find a job that offered her health insurance benefits.

She couldn't find a job she was qualified for that offered her the family health insurance coverage she needed. She ended up taking a job with a small employer that pays about $16,000 a year and offers her full-paid health coverage for herself only.

"I took the job because my employer has a group plan with an HMO whose rates I had checked out when I was self-employed. I knew I was going to have to really struggle to come up with the $60 a month for Anna, but I figured I would have to do it somehow."

Julia received a real shock when she tried to get Anna on the $60 a month plan for children of self-employed parents.

"I was so angry." Julia said. "The HMO told me that since my employer had a company policy that I would have to put Anna on that policy. The monthly payment would be much higher and way out of my reach."

The HMO expected Julia to pay $140 a month for Anna instead of the $60 she would have paid for her if she were self-employed.

"I can't believe it. I took this job so I could get health insurance for my daughter and I still can't afford it plus Anna now goes home to an empty unsupervised house because I can't afford child care either."

When we told Julia about the efforts to expand the age limit for the Children's Health Plan, she said, "I should spend my time praying for the Children's Health Plan instead of trying to figure out a way to get afforable health insurance on my own."

To come, story #7: These parents of five children in western Minnesota both work, but haven't had any health insurance for 10 years.

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HERE FAMILY STORY #7

Bob and Judy and their five children live in a small town in a western Minnesota county.

"Don't even say which county. If you use the name of our county," Judy says, "people up here will know it is us and alot of them don't like people 'who talk about problems'."

Judy and Bob don't want "problems." They want affordable health insurance. Bob works full time doing small engine repair and Judy works part time in an office. Together they make about $16,000 a year, not enough, Judy says, to buy health insurance. So when they get a medical bill they try to pay it.

"We haven't had health insurance for about ten years," Judy says. "I thank the Lord we are blessed with five healthy children. I don't want to talk about, much less think about, what we'd do if something went wrong."

Judy will, however, tell stories of some near misses. Like the time when her 2-year-old daughter, Nora, was playing in a boat stored in their yard and pulled a ground wasp nest out of the bottom of it. Her face was immediately covered with masses of wasps. Luckily, Judy says, someone was there to pull her away from the wasps. Nora escaped with 25 wasp stings on her face, and Bob and Judy escaped with a doctor bill that could have been alot worse.

"When you don't have health insurance," Judy says, "you have to have faith that things will work out."

"Now we are blessed with the Children's Health Plan for our three youngest children." Judy says they are lucky because most of the doctor visits have been for the younger children. Their youngest child, she says, is the one who gets most of the colds and ear infections.

But now some of that luck Judy talks about has run out. One of their children, Kevin, just turned 9 and is no longer eligible for the Children's Health Plan. Kevin needs special glasses, a major expense for a family with Bob and Judy's income.

"I really hope they expand the Children's Health Plan to the age of 18 or pass this Healthspan Program you told me about. If you think it will help the cause any, go ahead and mention what county we live in."

Judy and Bob live and work in Ottertail County

To come, story #8: This Polk County family of 6 has 3 children with chronic ear problems, but their 9-year-old has just become ineligible for the Children's Health Plan.

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HERE IS FAMILY STORY #8

Ted and Debbie Nelson of Polk County have three children with chronic ear problems. Amanda, who is 4, has been on antibiotics almost nonstop since she was six months old. Gretta, age 6, has a partial hearing loss from recurring ear infections, and Nick, age 9, continues to have lots of earaches.

And if it weren't for the Children's Health Plan, Debbie says her family would also have lots of unaffordable doctor bills.

"I've been so relieved," Debbie says, "to have three of our four children on the Children's Health Plan this winter."

Debbie, however, has just lost some of that feeling of relief. Nick turned 9 last month and like his 12-year-old brother David is now ineligible for the Children's Health Plan.

Debbie and Ted don't have any health insurance for themselves either. When they go to the doctor, Debbie says, they have to figure out some way to try to pay the bills.

"It seems like it costs $50 just to walk into the doctor's office, and by the time you get it paid for it's time for someone else to go."

Fifty extra dollars does not come easily to the Nelson family. Ted works as a self-employed carpenter and the Nelson's supplement this income with a modest 15-head herd of beef cattle.

"It's harder and harder for Ted to make good money," Debbie says. "A lot of the men doing carpentry around here have wives who are bringing in a second income, so they can afford to bid a job low."

Debbie says she'd like to get a job to help out. "But by the time I pay for child care and put enough gas in the car to get to town, where there are only minimum wage jobs, any money I could make would be nearly gone."

Debbie worries about Ted and her not having health insurance. As a carpenter he's climbing up on barns and other structures all the time. "Sometimes I work with him. I pass him up shingles so he doesn't have to go up and down the ladder so much."

When asked if she goes to the doctor for yearly pap smears, Debbie sort of chuckled and said "I haven't been to a doctor in over five years. I don't even know what a physical is anymore or how much it costs."

Without affordable health insurance, Debbie says her family, like hundreds of thousands of others in their situation, "Just have to cross our fingers and hope none of us have to go to the doctor."

To come, story #9: Unisured working mother says "I never should have given up welfare."

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HERE IS FAMILY STORY #9

Michelle couldn't wait to get off of Aid to Families with Dependent Children (AFDC). She was tired of the stigma, the poverty, and what she said were miles of paperwork. She had a part-time job selling ads for a community newspaper in her Minneapolis neighborhood but was painfully aware that if she made even one dollar over the allowable income level she would lose her much-needed Medical Assistance for her and her two children, Yolanda, age 8 and Jamal, age 10.

"I reached a point though," Michelle says, "where I just couldn't stand the stress any longer and told AFDC to keep there darn money."

Without the AFDC hassles , Michelle was able to work more hours. Her income rose to an average of $750 a month. When asked how she makes it on that, she says, "Barely. I'm on Section 8 housing and only have to pay 1/4 of my monthly income for rent. But I'm worried about my kid's health coverage."

Michelle's looking for a job that offers her some sort of help with health insurance. "The kind of work I'm doing, sales," Michelle says, "doesn't seem to come with health insurance as a benefit. I don't know how I'm ever going to be able to get Jamal's underbite corrected."

Jamal's underbite, Michelle says, is bad enough to make him extremely self-consious. "I feel terrible knowing that it is only money that is keeping me from helping my son with what is a psychological as well as a physical problem. Maybe I made a mistake getting off AFDC."

Another thing that bothers Michelle about her lack of health insurance is the inconsistent health care she and her children receive. "We go from clinic to clinic looking for the best deal," she says. "I know it's important to get consistent care but I also know you need money or health insurance to get it."

When we told Michelle about efforts to expand the Children's Health Plan to cover older children, she remarked, "You mean I won't have to fill out three miles of paperwork and I won't have to worry about losing it over one dollar too much? Sounds like a great deal. Sounds like a reason not to go back on AFDC. Let me know if I can help."

Two days after this interview, Michelle agreed to let a local T.V. station into her home for an interview. While many families feel too invaded, Michelle was quick to accept.

"It's the least I can do," she says, "to help my children and other children get adequate health care."

To come, story #10: A pregnant battered woman will lie, if necessary, to get health coverage but even that won't help her daughter, age 9, who needs counselling.

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HERE IS FAMILY STORY #10

Jim punched Margaret twice, hard, smashed a window and flung an air conditioner from above his head onto the floor. Then he picked up the phone to call Medical Assistance and accuse Margaret of lying about her income.

Margaret, who is pregnant, and her two children, Debbie, age 1 and Lizzy, age 9, are now sleeping on the living-room floor of a friend in St. Paul. Jim is in jail for the weekend. Margaret is not going back to Jim, she says, and is looking for an affordable apartment, but not having much luck.

"He's right about Medical Assistance. I did lie. My father sends me $200 a month that I haven't been reporting. That money, combined with the money I get from waitressing, would disqualify me. I felt like I had no choice but to lie. I'm scared not to have health insurance for my children and I can't afford to by any."

We explained to Margaret that because she's now pregnant Medical Assistance guidelines are higher and she will be able to get Medical Assistance for herself and the baby until the baby's one year old without lying. We also told her that Debbie will qualify for the Children's Health Plan. Margaret says she is willing to suffer the consequences, whatever they are, for lying to Medical Assistance. "All I want," she says, "is that I get adequate prenatal care and that my children get the medical attention they need."

Margaret let out a stream of frustration when we told her Lizzy was too old for the Children's Health Plan. "It feels like everywhere I turn someone throws a punch at me. Rent's too high. Child care's too high. Just what am I supposed to do about Lizzy?"

Lizzy's teacher is urging Margaret to get Lizzy into counselling. "It's been so ugly for her at home," Margaret says. "All this violence she's seen, I know it's affected her in a real bad way. Jim's not her father and she's never liked him. Why should she? She's lived in terror never knowing when he was going to strike out at me. She'd have a good chance in counselling now that she knows I won't go back to him."

But Margaret doesn't see how Lizzy is going to get that chance. Buying health insurance for her daughter is out of the question Margaret says. "Buy health insurance? What a joke, I can't even put a roof over our heads."

To come, story #11: A Richfield family is hounded by bill collectors because their 10-year-old is accident prone.

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HERE IS FAMILY STORY #11

Judy feels like she spends half of her life on the phone with hospital and clinic collection agencies who, she says, are trying to get blood out of a turnip. A typical conversation, she says, goes something like this:

Bill Collector: "You're going to have to send us a check for $287.76."
Judy: "I don't have $287.76."
Bill Collector: "This is a bill you owe. Don't you pay your bills? Don't you think you should have to pay your bills? The doctor didn't refuse to help your children. Are you refusing to pay the doctor?"
Judy: "We try. We only make enough money to buy food, pay rent and other essentials."
Bill Collector: "This is essential. How are you going to pay this bill?"
Judy: "I don't know. Maybe we could manage $20 a month instead of the $10 we're sending."
Bill Collector: "No. That won't do anymore. Send half of it now and half when you get your next paycheck."
Judy: "We don't have half of it. We don't have any extra money. We won't have half of it next month. I told you that last week and the week before. We can't do a damn thing but send you $10 or $20 a month."
Bill Collector: "You don't have to swear at me Judy. There is no need to be vulgar. You have a bad attitude. You owe this hospital money. We're just going to have to take you to court." (He slams the phone down.)

Judy, Tom and their three children, Desiree, age 10, Lori, age 5, and Jasmine, age 4 months, live in Richfield. Tom is a maintenance man at a health club and Judy works part-time at a warehouse. Together they gross about $20,000 a year.

When we told Judy and Tom that they could get Lori on the Children's Health Plan and Jasmine on Medical Assistance they were very appreciative but quick to point out that it was their 10 year old, Desiree, who is the main reason for their present bills of $1,100.

"She's had three accidents in the last ten months," Judy says. "She fell and got six stitches in her lip. Then she split open her chin a month after that and then about two months later she fell off her bike and we had to take her to urgent care." "You forgot about her abcessed tooth," Tom says.

Tom and Judy feel they work hard for their money. "If it weren't for these hospital and doctor bills, we'd have it made good enough," Tom says. "We don't want much," Judy says. "If you could get this Children's Health Plan for Desiree too, we'd really appreciate it. It'd be great to pick up the phone without having to hold my breath."

To come, story #12: Uninsured mother of three delivered premature baby due to hypothermia.

1989

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THESE ARE REAL PEOPLE . . .

400,000 Minnesotans Have No Health Coverage

HERE IS FAMILY STORY #12

"You put your life on the line, spill your guts, fill out 500 feet of forms and still they turn you down."

Regina's talking about applying for Medical Assistance in Hennepin County, where she lives. She thought for sure that her family would qualify for help. She works three part-time jobs (cleaning houses, selling tupperware and selling Avon) and her husband, Thomas, works as a welder. They have three children, Rowena, age 2, Clifford, age 6, and Clarissa, age 12. If Thomas doesn't get laid off, as he often does, Regina says their income will be about $16,000 for 1989. She knows that's too much for Medical Assistance.

"Now you know that not *one* of those people who decide how much you can make to get Medical Assistance knows what it's like to try and support a family of five on $16,000. And you also know none of those people live on my block."

When we tried to tell Regina about the Children's Health Plan and that her two younger children would qualify, she told us she wasn't done talking about Medical Assistance.

"We really needed help when I was pregnant with Rowena. Two days after Medical Assistance turned us down, our furnace broke. I ended up with hypothermia and the baby was born premature. The hospital is still trying to squeeze $3,000 out of us. Spend down? Don't even talk to me about spend down. Nobody told us to apply to Medical Assistance for the $3,000 until it was too late."

We tried to bring up the Children's Health Plan again. Regina says if they expand the Children's Health Plan to the age of 18 then our government would be on the right track in taking care of it's children.

"The way you have that Children's Health Plan now is terrible. How did that ever happen? Did the people who passed it only have children under 9 years old? What would I tell Clarissa if she got sick? 'Sorry, kid, you're too old to go to the doctor?'"

When Regina's children get sick now she brings them to a clinic run by the Minneapolis Health Department.

"It's only open once a week so I sometimes wait longer than I should when one of my kids is sick," Regina says. "But at least they don't slam the door in your face because your family makes a lousy $16,000 a year."

To come, story #13: Family with sick children "too proud" to apply for Medical Assistance

1989

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THESE ARE REAL PEOPLE . . .

400,000 Minnesotans Have No Health Coverage

HERE IS FAMILY STORY #13

It's a hard life in Pine County for the Olsens, but you won't hear them asking for help.

Five days a week Kris drives Noreen 30 miles to her job as a nurses aide, then goes home to their two children Kevin, age 17, and Kris Jr., age 2. Later that day, he makes the trip again to pick Noreen up. All this driving adds up to 120 miles a day and wages of about $550 a month.

Kris' unemployment check of $50 a week brings the Olsen's family income up to $750 a month.

Yes, this family qualifies for Medical Assistance. But Noreen says Kris won't let her apply for Medical Assistance. Like many Minnesotans, Kris wants to be able to take care of his own family.

"He'll never change his mind," Noreen says. "I wish he would, though, because Kris Jr. has chronic ear infections and the doctor says he needs tubes. I don't know how we will ever pay for them. And Kevin gets upper respiratory infections. We've already taken him to the doctor twice this year."

How do the Olsens pay their medical bills? "A little at a time," Noreen says. "But some of the bills end up with a bill collector and that's so frustrating. They harass you and make you upset and ruin your whole day. Kris Sr. has a hernia right now but won't go the the doctor because of the expense."

Nobody knows how many Minnesota families there are like the Olsens, families who are squeezing everything they can out of their few dollars and not applying for government funded programs because, like Kris, they are "too proud."

"If there was only some kind of health insurance," Noreen says, "where we could at least pay something, I know Kris would feel okay about it. But there's nothing we can even begin to afford. Nothing at all."

To come, story #14: Newly widowed mom of five faced with losing health care for her children, one of whom has cerebal palsy.

1989

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THESE ARE REAL PEOPLE . . .

400,000 Minnesotans Have No Health Coverage

HERE IS FAMILY STORY #14

Sue's husband, Ralph, died in an automobile accident last September. Suddenly Sue was a single parent responsible for all the needs of her five children, one of whom has cerebal palsy.

There are no luxuries for this Pine County family now. Sue runs her household on a bare bones' budget.

"It would be nice," Sue says, "if I could take the children to McDonalds or to a movie once in a while. They've been through a lot, losing their father, and it would help them take their minds off of it."

Unfortunately, Sue's income from Social Security payments and her part-time job delivering newspapers only takes care of absolute necessities. Sue's health insurance payment takes a big bite out of her monthly income. But health insurance, Sue says, is one of those absolute necessities for her family.

"So far," Sue says, " I've managed to make the $283 a month payment." She says, however, that somewhere down the line it could become a struggle to keep her family going on their budget. Unforseen expenses are a constant worry to a family on a tight budget.

"Just last week," Sue says, "the car died and I had to get a different one It scares me not to have a car when I have five children and we live nine miles from the closest town."

If Sue didn't have her $283 a month health insurance payment she says she would have bought a more trustworthy car than the one she squeezed out of her budget.
We tried to help Sue figure out a more afforable health insurance plan. Her monthly income is low enough so that her three youngest children would qualify for the Children's Health Plan.

"That wouldn't be any good for Crystal, though," Sue says. "She may have to be operated on for her cerebal palsy someday and the Children's Health Plan wouldn't cover the whole bill. Besides I'd still need health insurance for my other two children and the plan I have now wouldn't be that much less if I took the three youngest ones off."

Next we told Sue that the Children's Health Plan may be expanded to the age of 18 and then all of her kids could be covered. She said she would still need health insurance for herself and that alone is expensive.

"Just last week," Sue says, "I had a heart palpitations. I need to go in for a check up."

It's a hardship for this newly widowed mother of five to come up with the $283 a month for health insurance. Passing Healthspan is the best chance Sue's family has for affordable health care.

To come, story #15: Mother can't afford counseling for her abused daughter.

1989

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THESE ARE REAL PEOPLE . . .

400,000 Minnesotans Have No Health Coverage

HERE IS FAMILY STORY #15

"In the beginning, I only had to pay ten dollars a visit for Heather to see a counselor. I was unemployed, living on my savings and looking for work. They charged me according to a sliding fee scale," Judy Bigfeather says.

Judy's 13-year-old daughter, Heather, is a victim of sexual abuse. She had been repeatedly abused for two years by a "friend" of the family. For six months after the abuse, Heather saw a counselor at a mental health clinic in the Twin Cities. During that time, Judy was able to pay for Heather's weekly visit without much financial strain.

Then Judy found a full-time job and Heather's rate for counseling went out of Judy's reach. Judy, a single mother, was taking home $250 a week and needing every cent to make ends meet.

"I quit taking Heather to counseling. She'd been seeing a therapist throughout the whole court ordeal so I figured she had worked through most of her problems. But now when I think back on it I know the real reason I stopped taking her was the rate increase. I couldn't afford it but I didn't want to admit I was not able to help my daughter."

If there were affordable mental health coverage for Heather, Judy says she would take her back right now.

"There are signs," Judy says, "that Heather needs more counseling."

Heather's grades, Judy says, have been going down ever since she stopped going to counseling.

"I know I can't prove it's because I quit taking her to counseling, but it doesn't seem like there's anything going on in her life right now that would cause her grades to slip like that."

Judy says Heather's teacher expressed concern about Heather's grades and her lack of self-confidence at her last parent-teacher conference. The teacher asked Judy if anything was going on at home that she should know about.

"I don't want to tell her about the abuse," Judy says. "I don't want her to feel sorry for Heather or feel as if everything is related to the abuse."

Judy said to let her know if the Children's Health Plan is expanded so she can take Heather back to counseling.

"Let me know, too," she says, "if they pass Healthspan. I thought I had dealt with everything related to the abuse, but I think I could use some counseling myself. Maybe it would make me a better mother to look at it again. I still have alot of hurt and anger left inside."

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Chairman DURENBERGER. In partial response to that, I didn't introduce Ed Howard over here who is the No. 2 person on the Commission staff. But he also was the staff counsel to the House Aging Committee when Senator Pepper as he is more affectionately called was the Chair of the House Aging Committee. And I think Ed would probably agree that Congressman Pepper, for all his feeling, could not have expressed better here today the sense of urgency, of wrong, of stupidity, of inequity, or whatever, than has been expressed by all of our witnesses today. And I think he would be proud of all of these Minnesotans. So there are a lot more people out there ready to make a decision than you think.

And if I can use an analogy, I suppose, this Commission is very much like another commission. If you remember in 1982, the Social Security system was in crises, and 32 million people were about to be without their social security. It then took a commission—I hate to say this is a solution to all problems, but it took a commission then headed by Alan Greenspan but largely with members of the Senate and the House on it, better part of a year to do something. Then all of a sudden in the beginning of 1983 they kind of came back together, and they said this problem must be dealt with, it was one of those: "If not us, who? If not now, when?" deals. And they did it.

And in that same sense, if the Chair of this Commission were here today, Congressman Pepper, he would tell you that this is the "If Not Us, Who? If Not Now, When?" Commission. And our deadline is the middle of November 1989. And I am confident that somehow we are going to be able to come up with this because the people in this Commission are the ones that care the most, who have had the most of these hearings, been exposed to all of the people who know more than we do about this problem. It is what happens after November 1989 with the rest of the members and the members of the administration that are going to be very crucial.

So thank you for that challenge, all of you. We thank you for your testimony. And we are going to call on our third panel. Thank you very much. [Applause.]

Now, we have five persons on our next panel. The first is Mr. Don Wegmiller who is the president and chief executive officer of Health One Corp., past chair of the board of trustees of the American Hospital Association, been in the health care business over 25 years.

Dr. Jim Reinertsen, who is president and chief executive officer of Park Nicollet Center, a fellow of the American College of Physicians, and our host today.

Pat Drury, executive director of the Minnesota Coalition on Health, former independent consultant in new program development in health care, and also a past analyst for the Department of Health and Human Services in Washington, DC.

Mr. Harry Sutton, vice president with the firm of Tillinghast, which is a Towers & Perrin company, a fellow with the Society of Actuaries, and consultant with the Governor's Commission on Health Plan Regulatory Reform in Minnesota, a member of the Advisory Committee for Health Care Financing Administration, been very involved with the prospective payment organizations, PPO's, a

lot of experience in advising employers on how to deal with the problems that we have heard today.

And Sheila Leatherman, vice president of research and development of United Health Care, chairperson of 88 Minnesota HMO Council, board of directors of the Advisory Committee on Managed Care, Joint Commission on Accreditation of Health Care, on and on.

And I will not read everyone's credentials. They will have 5 minutes to prove all of the wonderful things they have done in their lives and are going to make a contribution in providing universal access for all Americans.

Literally, I suppose, the simple way to describe this group of people is that one way or another they have participated in and been involved in the minirevolution in the financing of health care and the delivery of health care that's taken place in Minnesota over the last 10, 12, 15 years, which nobody in the rest of the country seems to know a whole lot about, but everybody here has been deeply involved in.

And I think we are going to try to find in some of Minnesota's experiences some clues to what the Nation ought to look for or avoid, as the case may be, as we try to make affordable health care available to all Americans. So we will begin with the past chairman of the board of trustees of the American Hospital Association and the president of Health One, Mr. Don Wegmiller.

STATEMENT OF DON WEGMILLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HEALTH ONE CORP., AND PAST CHAIR, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

Mr. WEGMILLER. Thank you, Senator.

We'd also like to applaud, as the previous speakers have, this hearing in behalf of the American public and the Bipartisan Commission's interest in this important area.

Probably from the Minnesota hospital's perspective and the American hospital's perspective, we think that the situation with regard to the lack of access to health care for the 37 million Americans who are currently uninsured is clearly wrong. And what we have done in the past to deal with this issue, although it may have worked somewhat, probably was wrong. Our situation at the present time probably is wrong. And our circumstance, unless it is changed in the future, clearly will represent a furtherance of this wrong.

As not-for-profit hospitals, and with but a few exceptions all of the hospitals in Minnesota are not-for-profit, a significant part of our mission, our reason for being as hospitals, is to care for the poor, to provide access to hospital care for the uninsured. We have historically provided great amounts of such care and should and will continue to do so. The system changes that have taken place however in health care delivery have reduced the resources available and subsequently have reduced the hospital's ability to provide such care for the uninsured.

Let me just trace, if I may, to set perhaps the scene for the other speakers, the history of access to hospital care for the uninsured in

Minnesota, probably not a different history than the history you see in other States as well.

Where were we? Prior to the extensive prepayment health care plans that we have today, back in the thirties and forties, hospital care was actually quite accessible for those unable to pay because there was a strong philanthropic support for hospital care unable to be paid for. In essence, hospital deficits, operating deficits, caused by those unable to pay were picked up, if you will, by philanthropy. And although that system may not have been "right," it certainly worked.

As Blue Cross and other prepayment plans developed in the fifties and sixties, hospitals shifted the costs of treating the uninsured, which they continued to provide, to those who were able to pay by spreading those costs across the charge payers. It was an understood system. The plans understood it. Everyone knew that those costs were being spread. And although it may not, again, have been right, it in fact provided hospital care to the uninsured and provided access to that care.

As Government payment plans, Medicare and Medicaid particularly, came into being in the mid-1960's for the elderly and the poor, a number of the uninsured received their hospital care through these programs.

And during this era from the mid-1960's to the early 1980's, hospitals were compelled and were able to subsidize the cost of care provided to the uninsured by increasing the charges to the privately insured, to the governmentally insured, and to the private pay patients. Again, massive cost shifting for that uninsured.

This probably wasn't right any more than the current system is right, but it was a system that everyone understood, everyone participated in, and provided access to care.

Where are we now? Between 1980 and 1985, some fairly dramatic, perhaps not noticeable, but dramatic nevertheless, shifts in the ability of hospitals to continue this pattern, subsidizing nonpaying patients, has declined sharply.

Now, the principal sources of Government financing, Senator, Medicare and Medicaid, provide no subsidies any longer for the cost of indigent care.

Private insurers and, in Minnesota in particular, the burgeoning HMO's and PPO's only pay for the cost of care for those individuals enrolled in their plans. In Minnesota these payment sources, Medicare, Medicaid, HMO's, PPO's, prospectively set their payments at the cost level or, at below the costs of rendering care now representing 80 percent or more of all the payments to Minnesota hospitals, none of which includes any subsidy for the care for the uninsured.

Therefore, essentially, this subsidization that I described in the previous 40 or 50 years has ended. And the subsidization of the medically indigent no longer exists.

What should be done? I won't speak to other aspects of the delivery system. Our other speakers will do that. But from the hospital's perspective, we have seriously looked in this 5-, 6-, 7-, 8-year period as to what could we do to continue our mission of caring for the poor, the medically indigent, those uninsured.

We remain committed to do so. In 1987 hospitals in Minnesota rendered $60 million of uncompensated care. In 1988 that figure is likely to be larger. And we will continue to do so, probably right up until the last dollar of resources are available in hospitals. I would hope that day doesn't come soon, but at the current rate it very well may.

We have examined three things. Can we, for example, use operating margins, excess revenues over expenses, to support this care as we have done in the past? Unfortunately, the answer is no because there are no margins left in hospitals in Minnesota.

In 1987 the 180 hospitals in Minnesota lost collectively $6.8 million on their operation. They not only have no subsidy left to provide to others, they are now in jeopardy of being unable to provide the care for those who are enrolled and paying for their care.

In 1988 the preliminary figures suggest that operating margins will beat a modest surplus. All industry analysts and those of us in hospitals understand that you can't continue to operate hospitals on that basis. People would suggest that there needs to be a 4- or 5-percent margin if we are going to buy new equipment, replace equipment, and replace obsolete facilities. This would suggest that just to remain viable in providing the care we are charged with providing there needs to be margins of $125 million or $150 million. And there are no margins left in Minnesota hospitals at all, not taking into account what we might try and do for the uninsured over and above that.

A second area is to take whatever reserves are left and to spend them down. Basically, using Representative Ogren's figures, if we took all of the reserves that were left for buildings, for equipment, for replacement of anything and just said: "Look, we have to do this. We are going to spend all of those reserves. We don't care what happens in the future," we would probably be able to provide access to care for the uninsured for another 18 months in Minnesota. And then the reserves would be gone.

We would suggest from the hospitals' perspective that we need two basic solutions as was proposed by the American Hospital Association 4 years ago in their report of the Special Committee on Care for the Indigent, a copy of which I will leave with the staff. First, it is initiatives to promote broader private insurance for the working uninsured. That will be talked about, I am sure, by other panelists. And the health span bill by Representative Ogren represents in our judgment an excellent model.

Second, initiatives to improve Federal and State funding. Medicaid is a primary example. Medicaid in this State is an efficiently functioning system, but it's underfunded. It can be the delivery mechanism for the uninsured if both the Federal Government and the State government are willing to fund it as it should be funded.

We believe there are solutions. The hospitals of Minnesota want to and have historically participated in those solutions, and we want to continue. We are excited about the Commission's interest in this area, applaud it, and look forward to further discussions with you.

Thank you.

Chairman DURENBERGER. Thank you very much, Don. [Applause.]

Dr. Reinertsen.

STATEMENT OF DR. JAMES L. REINERTSEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PARK NICOLLET MEDICAL CENTER, MINNEAPOLIS, MN

Dr. REINERTSEN. Thank you, Senator Durenberger.

In addition to the things you mentioned, I am first and foremost a practicing doctor, an arthritis specialist here at the clinic.

The main message I want to bring to the Commission today is that the United States is in danger of being kicked out of the club of civilized nations because of the way in which we provide access to health care for our poor and our uninsured. American physicians, nurses, hospitals, and clinics such as Park Nicollet provide care for which people come from all over the world. Yet 37 million of our own fellow citizens have limited or no access to that same excellent care system because they are uninsured.

I believe that the gap between the medical haves and the medical have-nots in America must and can be closed. And I wish to suggest to this Commission a means by which this could be accomplished without significant increases in total U.S. health care cost.

What I'd like to try to do today is to answer a question that has not been asked so far. And it's a hard question, one of the hard choices we have to make. Where is the money going to come from? My first choice would be to have it come from defense, or from S&L bailouts, or a variety of other things, because I am a doctor [applause] and my choices are clearly, my responsibilities are clearly, with my patients.

But I am going to take a harder stance than that. I am going to look within the health care system itself and ask the question: What could we do to make sure that we have enough dollars to provide insurance for those who are uninsured? It's abundantly clear from the previous testimony we have heard today that one component of the gap between the haves and the have-nots is that the poor and the near-poor are underinsured. And I agree wholeheartedly, and I don't plan to embellish on the earlier testimony. Rather, I'd like to focus on a less obvious other component of the gap between the haves and the have-nots, and that is that the haves are overinsured because of health benefits that are either mandated by State laws or written into insurance packages. That may be a rather unpopular viewpoint, but I think it's one of the hard questions we are going to have to face.

It's my belief that the average insured American uses more services than necessary for good health and that an important cause, not the only cause, but an important cause, of that excessive utilization, especially for outpatient services, is the richness of the benefit structure of most insurance packages.

I don't know who the original architects of health insurance were, but I suspect they'd be shocked to find out that the same premium dollars they had originally intended to use for care for pneumonia, childhood meningitis, broken hips, and cancer surgery, are now being stretched to provide care for warts, baldness, breast reductions, chiropractic therapy to improve one's tennis game, not to mention numerous unnecessary lab and x ray tests which are reasonably and persistently requested by informed patients who say: "I saw a program on TV which said I should have this test, and I

am entitled to it because my insurance pays for it." Now, the original architects of health insurance, I suspect, would be even more disappointed if they knew that in part because of the high costs of these broad and often State-mandated health benefits (a cost by the way estimated to be as high as 20 percent of the total premium, a number which curiously coincides with the number of Americans, 20 percent, who are uninsured), the employers of 37 million Americans can't afford to provide health insurance.

And they would be extremely discouraged, these same architects, to discover that despite ever broadening coverage and minimal or no copayments for a lot of services in health care, Americans are far less satisfied now with their health in the 1980's than they were in the sixties or fifties or even the 1920's.

For example, in the 1920's Americans recorded 0.82 episodes per year of what they called serious disabling illness. In the 1980's, they report 2.12 episodes per year of serious disabling illness. And this is despite an increase over that time from 2.5 to 5.0 doctor visits per year per average American, and despite rather remarkable improvements in objective measures of health over that timespan, such as longevity and infant mortality, and the numbers of effective treatments available.

We physicians are proud of the fact that in 1928 doctors could effectively treat or prevent maybe 5 or 10 percent of the 360 most serious illnesses in this country. And we can now treat, it's estimated, 50 to 55 percent of those illnesses. Because we can do that, and in part because the media have ascribed some true medical miracles to all of us, and in part because of the benefit structures I mentioned, Americans seek out those expected miracles in care whether or not they are actually available for the condition they have. And I would suggest that the national appetite for those medical miracles have outstripped our ability to provide them.

My observation as a physician and our observation here in Minnesota has been that inpatient utilization decisions, hospital decisions, are largely controlled by physicians, but that outpatient costs, the most rapidly rising costs in the system, are often driven by this combination of mandated benefits and unrealistic expectations for what might be accomplished.

And for all of those reasons I want to suggest to this Commission that as it struggles with the question of how to extend coverage to 37 million uninsured, which must be done in my view, that we should look seriously at the question, all of us who have insurance, at the issue of overinsurance.

I believe that the Commission should define a basic level of health benefits for all Americans which would cover necessary, effective, and appropriate prevention and treatment. This basic benefit package would not include those things I like to call "nice to have but not absolutely necessary." It could include coverage for such conditions, such as baldness and infertility, but with a substantial point of service copayment, perhaps weighted by income. I believe the reduction in health care cost for those Americans who now enjoy overinsurance would be more than enough to pay for the cost of those who have no insurance.

In summary, then, overinsured Americans do not necessarily gain better health status and certainly don't seem to be any hap-

pier about their health than they were before they had insurance. I see little medical risk in reducing the benefits mandated and otherwise to a basic level in order to fund universally available insurance at that basic, necessary, and appropriate level.

I said in opening that the United States is in danger of being kicked out of the club of civilized nations. I would suggest to you, think about it for a minute, if even one child dies of meningitis, or one woman doesn't get a critically needed mammogram, because of poor access to care, in a society in which the dollar needed for that child or that woman went instead to pay for wigs and warts, then we deserve to be kicked out of the club of civilized nations. [Applause.]

Chairman DURENBERGER. Right. [Applause.]

Dr. REINERTSEN. Finally, lest you think of me as the Grinch, let me assure you that as a doctor I understand how deeply people feel about coverage for important issues such as infertility. I am confident, however, that if presented with the choice between basic and necessary care for all Americans and millions of Americans not even getting the bare minimum care because others enjoy an abundant set of benefits, Americans will be big-hearted enough to make the tough decision.

Thank you.

[The prepared statement of Dr. Reinertsen follows:]

TESTIMONY (as read) May 25, 1989
BIPARTISAN COMMISSION ON
LONG TERM HEALTH CARE
AND THE UNINSURED
James L. Reinertsen, M.D.
Park Nicollet Medical Center
Minneapolis, Minnesota

Senator Durenberger, Ladies and Gentlemen. My name is . . .. I am a practicing rheumatologist and am President of Park Nicollet Medical Center, one of our nation's largest clinics.

The United States of America is in danger of being kicked out of the club of civilized nations because of the way in which we provide access to health care for our poor and uninsured. The American physicians, nurses, hospitals, and clinics such as Park Nicollet provide care for which people come from all over the world, yet 37 million of our own fellow citizens have limited or no access to the same excellent care system because they are uninsured.

I believe that the gap between the medical "haves" and "have nots" in America must and can be closed, and wish to suggest to this Commission a means by which this could be accomplished without significant increases in total U.S. health care costs.

It is abundantly clear from previous testimony at this and other hearings that one component of the gap is that the poor and near poor are underinsured. I agree and don't plan to embellish earlier testimony.

Rather, I'd like to focus on the less obvious other component of the gap, the overinsurance of those with "normal" health benefits as mandated by state laws. It is my belief that the average insured American uses far more services than necessary for good health, and that an important cause of that excessive utilization (especially for outpatient services) is the richness of the benefit structure of most insurance packages.

I don't know who the original architects of health insurance were, but I suspect they would be shocked to find that the same premium dollars they had originally intended to use for care for pneumonia, childhood meningitis, broken hips, and cancer surgery are now being stretched to provide care for the common cold, warts, baldness, breast reductions, and chiropractic therapy to improve one's tennis game, not to mention numerous unnecessary lab and x-ray tests insistently requested by patients who say, "I saw a program on TV which said I should have this test, and I want to know the answer, and I'm entitled because my insurance covers it."

The original architects of health insurance would be even more disappointed if they knew that, in part because of the high

costs of these broad and often mandated benefits (estimated to be as high as 20 percent of total premiums[1]), the employers of 37 million Americans cannot afford to offer health insurance. And they would be extremely discouraged to discover that despite ever broadening coverage, and minimal or no copayments for many services, Americans are far less satisfied with their health in the 80's than they were in the 60's, the 50's, or even the 1920's. For example, Americans reported 0.82 episodes of "serious disabling illness" yearly in the 1920's, and 2.12 such episodes in the early 80's! And this in despite an increase from 2.5 to 5.0 doctor visits per year, over this same time span,[2] and despite remarkable improvements in objective measures of health such as longevity, infant mortality, and numbers of effective treatments available. For instance, in 1928, doctors could effectively treat or prevent 5 to 10 percent of the 360 most serious illnesses. We can now treat 50 to 55 percent of these conditions, and the public, in part because of media hype regarding some true medical miracles, and in part because of benefits structures, actually seeks out those expected miracles, whether or not they're available. This national appetite for medical miracles has outstripped our ability to deliver them.

Our observation is that inpatient utilization decisions are largely controlled by physicians, but that outpatient costs (the most rapidly rising costs in the system) are often driven by the combination of mandated benefits, "entitlement" attitudes regarding care, and unrealistic expectations.

For all of these reasons, I wish to request that this commission, as it struggles with the question of how to extend coverage to 37 million uninsured, look seriously at the overinsured. I believe that this Commission should define a basic level of health benefits for <u>all</u> Americans, to cover necessary, effective, and appropriate prevention and treatment. This basic benefit package <u>could</u> include "nice to have but not absolutely necessary" coverage for conditions such as baldness and infertility, but with a substantial point of service copayment, perhaps weighted by income.

I believe the reduction in health care costs for those Americans who now enjoy overinsurance would be more than enough to pay for the costs of those who now have no insurance.

In summary, overinsured Americans do not necessarily gain better health status, and certainly don't seem any happier about their health than they were pre-insurance. I see little medical risk in reducing their benefits, mandated and otherwise, to a basic level in order to fund universally available insurance at that basic, necessary and appropriate level. I said in opening that

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[1]Gail Jensen, quoted in "Mandated Benefits May Be Out of Reach for Small Firms," <u>HealthWeek</u>, Dec 27, 1988, p. 10.

[2]Barsky, Arthur J, "The Paradox of Health," N Engl J Med 1988; 318:414-8.

the United Sates is in danger of being kicked out of the club of civilized nations. If even one child dies of meningitis because of poor access to care in a society in which the dollars needed for that child went instead to pay for wigs or warts, then we deserve to be kicked out of the club of civilized nations.

Finally, lest you think of me as the grinch, let me assure you as a physician that I understand how deeply the insured feel about their coverage for important issues like infertility. But I'm confident that, if presented with the choice between basic and necessary care for all Americans, and millions of Americans not even getting the bare minimum care because others enjoy an abundant set of benefits, Americans are big-hearted enough to make the tough choices.

Thank you.

JLR:jma

Chairman DURENBERGER. Thank you very much. [Applause.]

I am sure we are going to get very excellent statements from each of these panelists, but I must remind all the members of the panel that there is a young lady sitting in the front row with a sign that none of you can read. And the sign is to enforce the rules you knew about before we got here, which is that, despite the length of your statement, we are going to try to hold the presentation to about 5 minutes, I think. Is that our rule? So whatever she is holding up there must signify something.

Anyway, Pat, you are now on your own.

STATEMENT OF PAT DRURY, EXECUTIVE DIRECTOR, MINNESOTA COALITION ON HEALTH

Ms. DRURY. Thank you, Mr. Chairman.

I am the executive director of a coalition that consists of 55 relatively large corporate and public sector employers as well as 15 labor unions, plus hospitals, physicians, HMO's, and health insurers. Our organization was founded in 1980 with a primary mission of promoting a well-functioning, competitive market in health care in Minnesota as the means of achieving affordable, high quality care accessible to all.

My comments are directed to the experience of that organization based on my experience working with them in the past 2 years. I do need to note that these are my observations and do not necessarily represent the positions of any of our members.

The Twin Cities health care market is now one of the most competitive in the country, particularly among health plans. Employers encouraged this by actively supporting the development of HMO's and other health plans over the last 10 to 15 years. By now nearly 50 percent of the population of the Twin Cities is enrolled in HMO's, and another 20 to 25 percent are enrolled in other forms of preferred provider organizations. So we have three-quarters of our metropolitan area population in managed care plans. At the same time our employers are experiencing increases in the cost of health benefits on the order of 15 to 25 percent per year.

The question inevitably arises: Has this been the test of competition and has it failed? From the point of view of employers, who, I think it needs to be remembered, do purchase coverage for hundreds of thousands of people, there is some failure in containing rising costs. From the point of view of others in our society, there are other serious unmet needs that have been described earlier today.

Employers however do not entirely see this market as a failure. In my conversations with them they still look to the management of the health plans, both HMO's and non-HMO's, to bring about continuing improvement and innovation, and they look to competition among plans as the disciplining force that holds the most promise of leading to a balance of cost with benefits.

One year ago our organization commissioned the Louis Harris firm to survey employers because we too wanted to know if they were becoming disillusioned with the competitive health care system. We surveyed 300 employers that ranged in size from 75 to over 50,000 employees in the State of Minnesota. We found that

overall, employers were highly satisfied, and they thought their employees were highly satisfied. Overall, they were about equally satisfied with HMO's, with their own self-insured programs, and with the one preferred provider plan that was large enough to be significant in our survey.

It should also be noted that the health plan features that were most important to employers were related to service and access. Costs came in fourth in importance. On service and access different kinds of plans were ranked comparably. Employers did tend to equate a large provider panel with access to quality care. Closed panels, no matter who they were, were less likely to be ranked as excellent for providing quality care. I believe this reflects the absence of direct ways for employers and employees and citizens to evaluate quality and that this lack has been a major obstacle to the market achieving what was originally hoped.

Some of the greatest dissatisfaction was expressed with plans' ability to limit the growth in cost. Employers tended to rank their own self-insured programs relatively well for cost control, but these programs are not required to include benefits mandated for other plans and are not generally in a position of serving or subsidizing the uninsurable or beneficiaries of Medicare and Medicaid. And yet these needs remain in our society.

In my observation there are three elements that characterize Minnesota employers' attitudes and actions today.

First, employers are concluding that in order for all of us to realize the potential benefits of a strong competitive market, they themselves must become more sophisticated buyers. Accordingly, they are demanding much more information from plans. They want to be able to sort out which differences in cost are due to differences in patients and which are due to differences in the plans' actual abiiity to manage. They also want better ways to differentiate plans on the basis of quality and the appropriateness of care as well as cost.

Second, employers are concluding that their employees must become more responsible and cost-sensitive users of the care system. Many are therefore requiring more cost sharing on the part of their employees. More on that in a moment.

I do want to note there was one widely publicized case about 3 years ago where a large employer terminated its HMO contracts for nonunion employees and replaced the coverage with preferred provider arrangements that included employee cost sharing. Some thought at the time that this was the beginning of the end for the competitive market and for HMO's in Minnesota. Quite the contrary occurred, however, and that brings me to my final point.

Employers have started to see the cost problem as the need for active management of the practice of medicine and practice patterns according to explicit standards of care. They're looking to the plans' management and physicians to do this job.

The employer mentioned just a moment ago recently reestablished its relationship with an HMO company and permitted a return to first-dollar coverage for their employees who join that plan because they have confidence in that organization's ability to manage care. The employer will keep doing business with other

plans to maintain the competitive environment that they believe fosters continuing improvement.

To conclude, Minnesota has, I think, learned that competition in health care isn't easy for buyers or sellers and that without vigilant and informed buyers it won't automatically produce cost-effective care. It also won't take care of all citizens unless there is also explicit public policy to provide subsidies for those who cannot afford care or insurance. It's still an open question whether competition will produce forces strong enough to balance the pressure of rapidly expanding technology.

I do know that Minnesota, in spite of these questions, has not given up, and that it's employers, employees, providers, and plans are all working very hard to make the market work.

Thank you for the opportunity to share these comments with the Commission.

Chairman DURENBERGER. Thank you, Pat. [Applause.]

Our fourth witness on this panel is Harry Sutton.

STATEMENT OF HARRY SUTTON, CONSULTANT, GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM IN MINNESOTA

Mr. SUTTON. I have never been known to be able to talk for less than 5 minutes.

Looking at our U.S. system, revolutionary change does not seem possible. I have been asked to talk about areas other than what Pat is talking about—the very large employer—and go to the market of the small employer where possibly half do not have insurance coverage.

I'd like to address several things. Since the United States moves incrementally regardless of Winston Churchill, or maybe in response to what Winston Churchill says, I think there are methods that we can use to shore up coverage and minimize the number of uninsurable people through our employer-based system. Ninety percent of covered people, forgetting governmental programs, have coverage through employers.

I think if employers did not permit employees to opt out of coverage and made extended dependent coverage both required and available, the number uninsured would decrease. Because my son is graduating from college this week, I have to worry about where he is going to be covered for his health insurance, and how to buy it. I received eight applications in the mail where I can buy coverage for 6 months. I think employer plans could be expanded making it possible for employers to cover teenagers, at the employee's expense, 20-year-olds, who are not really working, or in the work force, without access to coverage.

Part-time employees are a major problem because if you work half-time, the cost of your medical benefits is twice as much related to the salary as it would otherwise be. Very expensive for the employer. And for large employers, again, flexible benefits, selections among multiple benefit options, are common. They should not be allowed to permit any employee not to have coverage, even though some employees now give cash if employees reduce or drop coverage.

But let's look at the segment of the market that we are concerned with, the uninsured. I will tell you that across the United States, and Minnesota is no exception, there is a real dearth of opportunity for coverage. First of all, very few carriers sell individual coverage. All of your big insurers, the Prudentials, the Aetnas, and so on, do not sell even to small groups (less than 25 lives), or very seldom. Even our local company, Northwestern National, sold its small group business and does not write it any longer.

The small group market is highly dependent on niche commercial insurers and Blue Cross, which have some good programs, but usually involve underwriting and rerating with big rate increases. The underwriting process enables the carrier, if the employer has no one who is impaired or a bad risk, to have a fairly competitive premium. But the administrative cost of writing a small group, whether it's in a trust or not, runs from 25 to 35 percent of premium, compared with a "Honeywell" or very large employer where the administrative cost may be only 5 or 6 percent.

We develop rates in our business for insurance companies. And I will tell you the inflation trend is about 30 percent a year. In other words, if you were to buy insurance as a small employer your costs would go up 30 percent every year, with current inflation trends.

Now, small employers primarily buy on a price basis. Pat talked about the large employer example where they're worried about quality. The small employer is worried about affordability of his buying coverage for his employees. And in many small employer cases the employee has to pay most of the cost; whereas, with the larger employer, half of them pay at least the full employee cost and about a third pay for the full cost of the dependents.

So that the problem we have in the smaller employer and individual market is that the individual has to make an economic choice about whether he will spend the money or not for health care. If he is in very good shape, he won't spend the money. Therefore he is not insured. If he gets sick, he has no insurance coverage.

Senator Ogren's bill and our Minnesota Comprehensive Health Association [MCHA] Program, which has 14,000 people who are uninsurable in it, somehow need to be melded together to produce an approach to the small employer and individual market that can get around the selection aspects of the individual needing coverage and not being able to purchase it because he waited too long.

I think Minnesota has very good programs. Our HMO programs are also reaching out to Medicaid and experimental groups without access. They're all very difficult to price out. I am often the one trying to estimate what the costs are—not who is going to pay them. And it's a very difficult problem.

Thank you.

Chairman DURENBERGER. Thank you, Harry, very much. [Applause.]

Our final witness on this panel is Sheila Leatherman.

STATEMENT OF SHEILA LEATHERMAN, VICE PRESIDENT, RESEARCH AND DEVELOPMENT, UNITED HEALTH CARE, MINNESOTA, MN

Ms. LEATHERMAN. The recent report of the National Leadership Commission on Health Care proposes restructuring the Nation's health care system and reports that issues to be addressed are three: Cost, quality, and access. I will use this as the framework for my comments on managed care experience in Minnesota.

Managed care has grown from an alternative to an established mainstream industry. It now covers a total in excess of 1 million persons in HMO's alone.

The first issue is cost. The managed care industry has established the methods and standards for cost containment. These have now been adopted by PPO's [preferred provider organizations], indemnity insurers, and even the self-insureds.

The Minnesota HMO industry reduced hospital inpatient days approximately 40 percent in one decade. According to a Rand study comparing fee for service system with prepaid managed care HMO members pay 28 percent less out-of-pocket costs. Although critics of managed care caution that such success and utilization management poses problems in quality, Dr. Robert Brook of Rand Corp. stated, quote: "Yes, there are incentives to reduce the use of services in HMO's, but there are also incentives to overprovide in fee-for-service medicine."

However, there are admittedly huge challenges remaining to manage costs. While we can make provider networks cost-effective compared with uncontrolled health delivery, there still exists the potential for long-term cost escalation. Problems of technology proliferation, high utilization due to consumer expectations, and costly benefits being mandated by the State, all are threatening.

Additionally, as Medicare and Medicaid have limited what they pay, hospitals and HMO's have been forced to shift costs. Accordingly, premium prices have risen sharply for employers, who then view this event as a failure of managed care. In 1988 the local newspaper stated that HMO's are increasing their charges up 5 to 17 percent, but did go on to write that the traditional plans are going up even faster and gave an example of Travelers Insurance up 25 to 30 percent.

Any discussion of costs must acknowledge the financial instability experienced by HMO's. In Minnesota 4 HMO's in 2 years were compelled into mergers or acquisitions. The reasons are multiple. These are a few: Rapid growth; an overzealous adoption of the competitive notion with impact on pricing; and the participation in Medicare and Medicaid.

Next I wish to comment on quality. Others in health care have talked about quality of care, but it is the managed care industry which has been required by Federal and/or State laws to have quality assurance programs. Therefore, even acknowledging the incipient state of the art, the managed care industry comparatively is experienced.

The Minnesota State Health Department in its white paper of January 1988 commented, and I quote: "Increasing the quality of health care provided by HMO's has come under attack. But many

discussions about quality of care simply take the fee-for-service standards of health service delivery as the norm. One cannot assume however that more health care services lead to better care." End of quote.

This quality issue is complex both cognitively and affectively. But the state of the art is making significant strides toward developing practice guidelines for appropriate care.

Access, the third issue. The National Leadership Commission stated that, quote, "The uninsured and underinsured tend not to seek help until quite sick, which makes them more of a burden on the system," end of quote.

The necessary resources to ameliorate this situation are money, capacity of the system, and capability of providers. The Minnesota experience with Medicare and Medicaid would illustrate a few of the critical issues.

First, systems problems. We must avoid further fragmentation. Multiple sources of payment create a Byzantine system that is costly and difficult to administer.

Second, financing. The burden of risk of HMO's has been too great. The losses become part of the premium paid by those buying group health insurance. Also, the cost of unpaid care is passed along to providers, creating further financial instability and increased contentiousness in relationships.

In summary, what does our managed care experience in Minnesota portend for the future? And what are the necessary actions? Regarding cost, it is necessary to make explicit the cost for all, that is, to remove costs subsidization or excessive risk assumption. Reimbursement must be fair and predictable to providers and also must avoid inequitable geographic variation.

Regarding access, there must be consensus around a level of services that is based on improving the health status of a population.

Regarding quality, until we can better define appropriate care, it is impossible to set meaningful standards for access or to devise prudent reimbursement methods.

In short, I do believe that managed care concepts and the experience may be instructive for planning an efficient health care system that provides universal access for all.

[The prepared statement of Ms. Leatherman follows:]

TESTIMONY

TO

UNITED STATES BI-PARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

MAY 25, 1989

Sheila Leatherman
Vice President
United HealthCare
Minneapolis, MN

THE RECENTLY RELEASED REPORT OF THE NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE PROPOSES A MAJOR RESTRUCTURING OF THE NATION'S HEALTH CARE SYSTEM AND REPORTS THAT THE NECESSARY ISSUES TO BE CONSIDERED AND ADDRESSED ARE IN THREE AREAS: COST, QUALITY AND ACCESS. I WILL USE THIS AS THE FRAMEWORK FOR MY COMMENTS ON THE MANAGED CARE EXPERIENCE IN MINNESOTA, AND THEN SUMMARIZE THE IMPLICATIONS OF MINNESOTA'S EXPERIENCE.

MANAGED CARE HAS RAPIDLY GROWN FROM AN ALTERNATIVE TO AN ESTABLISHED MAINSTREAM INDUSTRY IN MINNESOTA. ALTHOUGH MANAGED CARE IS BROADLY PRACTICED THROUGH NOT ONLY HMOS BUT PPOS AND CLINICS, I WILL CONFINE MOST OF MY REMARKS TO THE HMO INDUSTRY. HMOS ALONE CURRENTLY ENROLL OVER 1/4 OF THE STATE POPULATION AND WELL OVER HALF OF THE METRO POPULATION FOR A TOTAL IN EXCESS OF 1 MILLION PERSONS.

THE FIRST ISSUE IS COST WITH THE RELATED SUBJECTS BEING PRICE AND REIMBURSEMENT FOR SERVICES.

THE MANAGED CARE INDUSTRY HAS ESTABLISHED THE METHODS AND STANDARDS FOR COST-CONTAINMENT. THESE HAVE NOW BEEN WIDELY ADOPTED BY PPOS, INDEMNITY INSURERS AND EVEN THE SELF-INSURED.

THE MINNESOTA HMO INDUSTRY REDUCED HOSPITAL INPATIENT DAYS PER 1000 MEMBERS FROM 533 IN 1976 TO 295 IN 1986. THIS IS A REDUCTION OF APPROXIMATELY 40% IN ONE DECADE.

IN A 5 YEAR PERIOD FROM 1981 - 1986 HMOS REDUCED HOSPITAL LOS FROM 4.74 TO 3.76. THIS DURING THE SAME PERIOD OF TIME THAT COMMERCIAL INSURERS WERE AT 6.40 DAYS IN '81 REDUCED TO 5.80. SO HMOS HAD LOS APPROXIMATELY 1/3 LOWER.

GHAA FACT SHEET 12/15/87

ACCORDING TO A 12 YEAR RAND STUDY COMPARING THE FFS SYSTEM WITH PREPAID MANAGED CARE, HMO MEMBERS HAVE 40% FEWER HOSPITAL ADMISSIONS AND PAY 28% LESS OUT-OF-POCKET COSTS. ALTHOUGH CRITICS OF MANAGED CARE WOULD CAUTION THAT SUCH SUCCESS IN UTILIZATION MANAGEMENT

POSES PROBLEMS IN QUALITY, DR. ROBERT BROOK OF RAND CORPORATION STATED, "YES, THERE ARE INCENTIVES TO REDUCE THE USE OF SERVICES IN HMOS, BUT THERE ARE ALSO OTHER INCENTIVES TO OVER-PROVIDE IN FEE-FOR-SERVICE MEDICINE."

HOWEVER THERE ARE ADMITTEDLY HUGE CHALLENGES REMAINING TO MANAGE COSTS.

WHILE WE CAN MAKE PROVIDER NETWORKS COST-EFFECTIVE COMPARED WITH UNCONTROLLED HEALTH SERVICE DELIVERY, THERE STILL EXISTS THE POTENTIAL FOR LONG-TERM ESCALATION OF HEALTH CARE COSTS. PROBLEMS OF TECHNOLOGY PROLIFERATION, HIGH UTILIZATION OF SERVICES DUE TO CONSUMER EXPECTATIONS, AND COSTLY BENEFITS BEING MANDATED BY THE STATE, ARE THREATENING.

ADDITIONALLY, AS MEDICARE AND MEDICAID HAVE LIMITED WHAT THEY PAY FOR MEDICAL CARE, HOSPITALS AND HMOS HAVE BEEN FORCED TO SHIFT COSTS. ACCORDINGLY CHARGES AND PREMIUM PRICES HAVE RISEN SHARPLY FOR EMPLOYERS WHO THEN VIEW THIS EVENT AS A FAILURE OF MANAGED CARE

TO CONTAIN COSTS. IN 1988, THE LOCAL NEWSPAPER, STAR & TRIBUNE, STATED THAT HMOS ARE INCREASING THEIR CHARGES (UP 5 - 17%) FOR 1988, BUT DID GO ON TO WRITE THAT THE TRADITIONAL FFS PLANS ARE GOING UP EVEN FASTER AND GAVE AN EXAMPLE OF TRAVELLER'S INSURANCE UP 25 - 30%.

ANY DISCUSSION OF COST AND PRICE MUST ACKNOWLEDGE THE FINANCIAL INSTABILITY EXPERIENCED BY HMOS. IN MINNESOTA, 4 HMOS IN 2 YEARS ('87 - '88) WERE COMPELLED INTO MERGERS OR ACQUISITIONS. THE REASONS ARE MULTIPLE --- THESE ARE A FEW:

1. RAPID GROWTH AND DIVERSIFICATION

2. AN OVERZEALOUS ADOPTION OF THE COMPETITIVE NOTION WITH IMPACT ON PRICING STRATEGIES, AND

3. THE PARTICIPATION IN MEDICARE AND MEDICAID WHICH CAUSED FURTHER EROSION OF FINANCIAL INTEGRITY.

NEXT, I WISH TO COMMENT ON THE QUALITY OF CARE ISSUE. OTHERS IN HEALTH CARE DELIVERY AND FINANCING TALK ABOUT QUALITY OF CARE BUT IT IS THE MANAGED CARE INDUSTRY WHICH HAS BEEN REQUIRED BY BOTH FEDERAL AND/OR STATE LAW TO HAVE QUALITY ASSURANCE PROGRAMS. THEREFORE, EVEN ACKNOWLEDGING THE INCIPIENT STATE - OF - THE - ART, THE MANAGED CARE INDUSTRY COMPARATIVELY IS EXPERIENCED.

THE MINNESOTA STATE HEALTH DEPARTMENT IN ITS WHITE PAPER OF JANUARY 1988 COMMENTED - AND I QUOTE:

> "INCREASINGLY THE QUALITY OF HEALTH CARE PROVIDED BY HMOS HAS COME UNDER ATTACK... BUT MANY DISCUSSIONS ABOUT QUALITY OF CARE SIMPLY TAKE THE FEE-FOR-SERVICE STANDARDS OF HEALTH SERVICE DELIVERY AS THE NORM. ONE CANNOT ASSUME HOWEVER THAT MORE HEALTH CARE SERVICES LEAD TO BETTER CARE. FOR EXAMPLE, MEDICAL EXPERTS GENERALLY AGREE THAT US CAESARIAN SECTION RATES ARE TOO HIGH." (END OF QUOTE)

THIS QUALITY ISSUE IS HIGHLY COMPLEX, BOTH COGNITIVELY AND AFFECTIVELY. BUT THE STATE-OF-ART IS MAKING SIGNIFICANT STRIDES TOWARDS DEVELOPING NEEDED PRACTICE GUIDELINES TO ENCOURAGE APPROPRIATE CARE AND TO IDENTIFY AND ELIMINATE UNNECESSARY CARE.

ACCESS IS THE THIRD ISSUE.
THE NATIONAL LEADERSHIP COMMISSION STATED THAT

> "THE UNINSURED AND UNDER-INSURED TEND NOT TO SEEK HELP UNTIL QUITE SICK, WHICH MAKES THEM MORE OF A BURDEN ON THE HEALTH CARE SYSTEM THAN THEY WOULD OTHERWISE BE."

THE NECESSARY RESOURCES TO AMELIORATE THIS SITUATION ARE MONEY, CAPACITY OF THE DELIVERY SYSTEM AND CAPABILITY OF PROVIDERS. THE MINNESOTA EXPERIENCE WITH MEDICARE AND MEDICAID WOULD ILLUSTRATE A FEW OF THE CRITICAL ISSUES.

FIRST, SYSTEMS PROBLEMS; WE MUST AVOID FURTHER FRAGMENTATION. MULTIPLE SOURCES OF PAYMENT AND THE MYRIAD PAYMENT PLANS CREATE A BYZANTINE SYSTEM THAT IS

COSTLY, AS WELL AS DIFFICULT TO ADMINISTER.

SECONDLY, FINANCING. THE BURDEN OF RISK OF HMOS HAS BEEN TOO GREAT. THE LOSSES FROM PATIENTS WITHOUT INSURANCE HAS BECOME PART OF THE PREMIUM PAID BY THOSE BUYING GROUP HEALTH INSURANCE.

ALSO, THE COST OF UNPAID CARE HAS BEEN ABSORBED OR PASSED ALONG TO PROVIDERS - BOTH DOCTORS AND HOSPITALS - CREATING FURTHER FINANCIAL INSTABILITY AND INCREASED CONTENTIONS IN RELATIONSHIPS.

IN SUMMARY,
WHAT DOES OUR MANAGED CARE EXPERIENCE IN MINNESOTA PORTEND FOR THE FUTURE AND WHAT ARE THE NECESSARY ACTIONS?

REGARDING COST:
THE INDUSTRY'S RECORD IS SOMETIMES DEBATED BUT MANAGED CARE HAS INTRODUCED COST-CONTAINMENT MEASURES LATER ADOPTED BY INDEMNITY INSURERS AND THE AVAILABLE FACTS SPEAK FOR THEMSELVES. THE INDUSTRY WILL CONTINUE TO INNOVATE AND PIONEER BENEFICIAL SYSTEMS IN COST-EFFECTIVENESS. THIS TYPE OF INNOVATION MUST NOW BE FOCUSED ON THE AMBULATORY SETTING(S). ADDITIONALLY, IT IS NECESSARY TO MAKE EXPLICIT THE COSTS FOR ALL; THAT IS TO REMOVE COST-SUBSIDIZATION OR EXCESSIVE RISK ASSUMPTION. REIMBURSEMENT MUST BE FAIR AND PREDICTABLE TO PROVIDERS AND ALSO MUST AVOID INEQUITABLE GEOGRAPHIC VARIATION.

REGARDING ACCESS:
THERE MUST BE CONSENSUS AROUND A LEVEL OF BASIC SERVICES ACROSS THE NATION THAT IS BASED ON IMPROVING THE HEALTH STATUS OF A POPULATION.

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REGARDING QUALITY:

UNTIL WE CAN BETTER DEFINE APPROPRIATE CARE, IT IS IMPOSSIBLE TO SET MEANINGFUL STANDARDS FOR ACCESS OR TO DETERMINE RATIONAL BENEFITS PACKAGES OR TO DEVISE PRUDENT REIMBURSEMENT METHODS.

IN SHORT, MANAGED CARE CONCEPTS STRATEGIES AND EXPERIENCE MAY BE INSTRUCTIVE FOR AN EFFICIENT HEALTH CARE SYSTEM THAT PROVIDES UNIVERSAL ACCESS TO A BASIC LEVEL OF APPROPRIATE AFFORDABLE CARE.

Chairman DURENBERGER. Thank you, Sheila. [Applause.]

Thank you all.

That's sort of an incredible view of where we have been over the last 10 years and where we all are today, and everybody did it in approximately 5 minutes. And I am very grateful to all of you for the efforts that went into that.

I might say to all of the witnesses that if we ever finish this hearing, which I assume will be right around the time that the Chair gets hungry, which is usually right around 12 o'clock, and we have yet to hear from our witnesses on long-term care, that if any of you are able to stick around and come on down and take a picture with this sign, because you may not get another opportunity between now and November, do it if you want to do it. Please feel free to do so. Besides, the next witnesses are just as good as the witnesses we have had in the past. So thank you very much for all five of you for being here.

Our next three panelists will discuss policy issues involved in this State and this country on long-term care.

The first is Sandra Gardebring, the commissioner of the Minnesota Department of Human Services for the last 2½ years, former chair of the Metropolitan Council, and former executive director of the Minnesota Pollution Control Agency.

Dr. Robert Kane, dean of the school of public health of the University of Minnesota for the last 3 years; former senior researcher at Rand and professor in the department of medicine at UCLA; member of the advisory panel on Alzheimer's disease for the U.S. Department of HHS; and on and on.

And Cynthia Polich, who is the president of Interstudy, a former research fellow at the Center for Health Services Research, University of Minnesota, and in 1988 selected by the health care forum as one of four emerging leaders in health care in the Nation in 1988.

We are so pleased for all of your past contributions to this issue, all three of you, which are legion already, and for your contributions here today, to have you agree to be part of this introductory panel.

We will begin with Commissioner Gardebring.

STATEMENT OF SANDRA GARDEBRING, COMMISSIONER, MINNESOTA DEPARTMENT OF HUMAN SERVICES

Ms. GARDEBRING. Good morning, Senator. And thank you for the opportunity to be here.

On behalf of the Governor and all of us in the Perpich administration who work on health care issues we want to thank you for your leadership in the Congress, and also for your advocacy in finding solutions for issues that we are identifying in Minnesota. We are very grateful.

Chairman DURENBERGER. Thank you very much.

Ms. GARDEBRING. As you know, the legislature completed its 1989 session this week and took up a variety of health care issues in Minnesota. Considerable time was spent debating these issues, and I think considerable progress was made in working on a number of health care problems.

First of all, the State's children's health plan, which provides basic health care services to children and families who do not qualify for Medicaid but who still exist in low-income families—that plan has been expanded to include children up to age 18 effective January 1991.

We also began laying the framework for a comprehensive new Children's Mental Health Program which includes a variety of community-based services, including specialized foster care and expanded the State's mental health program for adults, again, by expanding options for community support for adults with serious and persistent mental illness.

And the legislature approved a plan to move most of the persons with developmental disabilities now living in State hospitals out of those facilities and into community-based residential homes.

I think as this partial list demonstrates, we have continued in Minnesota to try to provide innovative solutions to ongoing health care issues, but it's quite clear that additional problems need to be addressed. And in the area of long-term care we know that there are many of them and we'd be glad to talk to you about that.

Just a few years ago Minnesota like most States had only one solution for providing services to the elderly, and that was institutional care. We have come a long way as many other States have. I think we are strongly committed to allowing our elderly citizens and our handicapped citizens to retain as much independence as possible for as long as possible. And, again, I think that's consistent with the issues that we have taken up in this session.

In the last 5 to 10 years Minnesota has I think provided leadership in creating a long-term care system that can serve as a model for other States. We have extended an extensive preadmission screening program. We have a variety of home care options, which we know aren't fully adequate as we heard testimony on this morning. We have provided mechanisms for long-term care insurance to be sold. We have a reimbursement based on resident needs system and a moratorium on nursing home bed levels. And that's all part of our continually changing system.

But we know even as we change this system that it's not keeping up with the needs and desires of our citizens or with the changes generally in the delivery mechanisms for long-term care. We are really on a whole different ball field than we were a few years ago. There are now new housing and home care blends. There are considerable shifts in consumer preference in what's available. There is an increasing number of elderly, particularly frail elderly, and we know that nursing home physical plants, at least in our State, are really not compatible with consumer choices anymore. And, of course, we have begun to try to deal with the changes in nursing home care mechanisms under OBRA 1987 and the Catastrophic Coverage Act of 1988.

For Minnesota to remain on the forefront of long-term care we need to begin planning for a future that meets the needs of our citizens 10 to 15 years down the road. In recognizing that that need exists, the Governor has appointed a multiparty commission directed toward establishing a long-term care agenda for the 1990's. We hope out of that commission will come additional recommendations for specific action for strengthening independent living options for

seniors. I think this supports generally the notion that while national long-term care policies will continue to emerge from Washington, Minnesota cannot and will not forsake its leadership role.

We now live in a world of progressive federalism as identified by the National Center for Policy Alternatives. The authors there identify that as a system of Government based on the reality of large Federal deficits, cuts in Federal spending, and yet the continuing need for expanded governmental response to the problems of its citizens.

Where we once looked exclusively to Washington for answers, States are now providing some of their own solutions. State initiatives in such areas as welfare reform, parental leave, and health care for the uninsured, including the proposal you heard discussed earlier today, have spread from State to State and become the basis for national policy debates, and I think that will continue to be true as well in the long-term care area.

So we have begun that leadership effort at the State level, but we also know that there are hazards in simply developing an assortment of isolated solutions. We also know that private sector options such as private long-term care insurance and new housing and service packages don't sufficiently address all the future long-term care needs.

In order to be successful at resolving these issues we believe that the Congress must work with States, and you have been very generous in your efforts to work with us, and we believe that that effort has to continue over a period of time as consumer choice changes, as demographics change, and as the solutions for this problem evolve.

English author John Ruskin once said on the subject of cooperation: "Government and cooperation are in all things the laws of life. Anarchy and competition are the laws of death." And we know if we want to solve this problem, we need to focus on that cooperation and we look forward to the chance to work with you on this over the next few years.

Thank you.

[The prepared statement of Ms. Gardebring follows:]

Prepared Remarks

Sandra S. Gardebring, Commissioner

Minnesota Department of Human Services

U.S. Bipartisan Commission on Comprehensive Health Care

May 25, 1989

Thank you. I want to add my "welcome to Minnesota" to those you have already received this morning, and I want to thank Sen. Durenberger for the opportunity to speak on some of the long-term care issues facing our state and nation.

Minnesota this week completed its 1989 legislative session, a session in which legislators spent considerable time debating a range of very important and significant health care issues. Of course, not all the health care bills passed, but a number of important health care features have become part of Minnesota law. For example:

- The state's Children's Health Plan, which provides basic health care services to children in families who don't qualify for Medical Assistance but whose income is under 185 percent of the federal poverty level, has been expanded to include children up to age 18.

- The state will begin laying the groundwork for a new comprehensive children's mental health system with the establishment of community- and family-based treatment services for children with serious mental illness.

- Minnesota's mental health system for adults has been strengthened with an expansion of community support services for adults with serious and persistent mental illness.

- And the legislature approved a plan to move most of the persons with developmental disabilities now living in the state's regional treatment centers - or state hospitals, as they were once called - into small, community-based residential facilities.

As I think this partial list demonstrates, a lot was accomplished during the session. However, a lot more remains to be done. And long-term care, on which I'll focus my comments this morning, is one such area.

A few months ago my mother suffered a slight stroke caused in part, I believe, by the strain of worrying about and caring for my sick father. While I was back in North Dakota visiting my parents at that time, we came to the difficult conclusion that my dad needed to be placed in a nursing home. It was not an easy decision to make, and it was not made before exploring other alternatives.

While I've had considerable experience working on long-term care issues as Commissioner of Human Services and as Chair of the Twin Cities' regional planning agency, it was this event that really brought home the need for a state and national vision for a comprehensive long-term care policy.

Just a few years ago, Minnesota's long-term care policy provided just one solution: institutional care. We've come a long way in a short time. Today we offer a continuum of services across the state, from home care to day services to institutional care.

Minnesota is strongly committed to allowing its citizens to maintain as much independence as possible for as long as possible. I've mentioned our efforts to create a comprehensive mental health system for children and adults and our plan to downsize the state hospitals. We are just as committed to provide alternatives to nursing homes as well.

In the last five to ten years, Minnesota has created a long-term care system that serves as a model for other states. Preadmission screening, home care options, long-term care insurance, case mix reimbursement, and a moratorium on nursing home beds are all part of a growing state system.

Where we once screened 2,300 people applying to nursing homes and provided Alternative Care Grants to 790, this year we expect to screen more than 20,000 people and provide community-based services to more that 6,600 elderly and 450 disabled. And those figures don't reflect the number of people who weren't eligible for the home care programs but who were directed to community services that allowed them to avoid placement in a nursing home.

But even as we continue to expand the system, it's not keeping up with the needs and desires of our citizens. We're playing on a whole different ballfield than we were just five years ago. There are new housing and home care blends, shifts in consumer choices and preferences, an increasing number of elderly, and nursing home physical plants whose configurations are not compatible with the preferences of consumers. And from another direction, the state must adapt to federal mandates such as OBRA 1987 and the Medicare Catastrophic Coverage Act of 1988.

For Minnesota to remain on the forefront of long-term care, we need to create a plan that meets the needs of our citizens five to 10 to 15 years into the future. Recognizing that such planning requires an interagency effort, we have established such a group to recommend by the fall of 1990 specific actions for strengthening independent living for seniors in order to plan for the next decade.

And while national long-term care policies will continue to emerge from Washington, Minnesota cannot forsake its leadership role. We now live in a world of progressive federalism, as Linda Tarr-Whelan of the National Center for Policy Alternatives calls it. It is a system of government based on the reality of a large federal deficit, cuts in federal funding, and the continued need for a governmental response to the problems of its citizens.

Where we once looked almost exclusively to Washington for answers, states are now providing some of their own solutions. State initiatives in such area as welfare reform, parental leave and health care for the uninsured have spread from state to state and have become the basis for national policy debates. The same has and will continue to be true for long-term care issues.

However, while states more and more recognize the importance of their own initiatives in long-term care, they also recognize the hazards of an assortment or isolated solutions. And, as Josh Weiner and Alice Rivlin have pointed out in their research, states know that private sector options such as private long-term care insurance and new housing and service packages don't sufficiently address all the future long-term care needs we face.

Because of the magnitude and volatility of this issue, a national long-term care solution is desperately needed. Certainly many of the measures contained in the Medicare Catastrophic Act, such as spousal impoverishment and expanded skill care benefits, were designed to address this national need. But we must go further.

The financial burden for long-term care still falls primarily on the victim. most elderly or disabled individuals cannot afford long-term care insurance or the cost of assisted living housing programs. When they need long-term care, they pay for it out of pocket until their resources are depleted and Medicaid is available. No other major Western industrialized nation forces this burden onto one of their most frail and vulnerable populations.

The time is right for serious consideration of a national public financing strategy which distributes the costs of long-term care across the population and across the states.

Several such bills have been or will be introduced into Congress. These proposals, created by a number of nationally respected groups, include a number of approaches for public financing from expansion of Medicare or Medicaid to totally new sources funded through premiums and estate taxes. We hope that this Commission will conduct an objective analysis of these concepts and will ultimately establish the principles on which a publicly financed long-term care insurance program should be based.

In order to be successful at this task, Congress and the U.S. Department of Health and Human Services need to recognize states as full partners in these deliberations. Our considerable technical expertise in administering Medicaid and long-term care programs are essential to solving many practical administrative problems inherent in establishing such a program.

Unfortunately, I cannot say in all honesty that I feel assured of having that partnership. Minnesota's recent experiences with the implementation of the Nursing Home Reform Act provisions of OBRA 1987 have not been positive. State advice was not seriously sought or considered during the development of that legislation. HCFA has largely relied on other interest groups during implementation. State involvement came late in the process and only after much complaining about being excluded. Yet it is the states who are left with the administrative program cost burdens of the changes.

If we are to have a successful long-term care system in this country, we will have to do better, especially if states are going to play a large role in administering such programs.

English author John Ruskin once said: "Government and cooperation are in all things the laws of life; anarchy and competition the laws of death." Your visit here this morning is an example of the kind of communication and cooperation needed between the state and federal governments. It is the kind of communication that must be continued and expanded.

Thank you.

Chairman DURENBERGER. Thank you very much. [Applause.]
Dr. Kane, thank you for being here.

STATEMENT OF DR. ROBERT KANE, DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MINNESOTA; MEMBER, ADVISORY PANEL ON ALZHEIMER'S DISEASE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. KANE. Thank you, Senator Durenberger. I think all Minnesotans want to send Senator Pepper our best wishes for a speedy recovery and hope that he doesn't face too much long-term care.

I think this country has been known as the land of the demonstration project. We are turned to by all the world for good experiments. Unfortunately we have no programs. If there is a theme to be taken away from our consideration of long-term care in this country, it's perhaps how to focus on buying more with the dollars we spend rather than our constant fixation with simply paying less.

I would like to suggest that we need to address three underlying problems in long-term care today.

First is universal coverage of basic services provided in an environment that comes with dignity and privacy. This means eligibility based on functional status and not on poverty. It means recognition and support for the critical role that families play in delivering long-term care historically and indeed in the present and in the future.

Second is to recognize that we are a country that takes great pride and places great importance on public-private mixes in terms of how we fund this care. Any solution we find has got to incorporate, I think, this mixture of public and private support.

And third, we desperately need greater creativity in the design of services and programs and to emphasize the results of care in terms of both quality of care and quality of life, rather than our fixation with trying to define exactly how that care is provided.

Now, I have two proposals to put to the Commission to respond to those three challenges. First, we clearly need universal coverage for services, but I would suggest that that coverage be directed primarily at care services rather than preserving the anachronistic mixture of residential coverage and care services. We need to break away from our old image of the nursing home, separate those two components of nursing and home, recognizing that what we want to provide for all Americans is, in fact, access to nursing care services. These could really be made available, while allowing greater variation in the way that residential component was being provided. Such a step would provide an incentive for people to save for long-term care in order to buy greater amounts of amenities, although we would clearly have to provide a minimal level of housing for those who are unable to afford it. This approach would be compatible with a private long-term care insurance initiative. It would also be compatible with perhaps what is even more appropriate, a strong commitment on the part of America to save.

We are going to need in such a system a strong role for case management in order to be sure that services are provided on the basis of functional needs and not on the basis of something more

easily measured, such as income. We are probably also going to need some role for copayments given the American propensity to take advantage of any system that's made available to them.

The second proposal that I would like to make is that we ought to be shifting the way in which we regulate this evolving long-term care industry. We have been the prisoners of professional orthodoxy for too long and have developed a number of rules that were well intentioned but have become strangulated in terms of the creativity that's available now to be able to provide meaningful long-term care.

I would suggest that we are now embarking on a revolution in acute care that we need to match in long-term care. Long-term care has too often been doomed to repeat all the mistakes of acute care before it can create its own path. In long-term care particularly there is a need to begin to look at the degree to which we achieve the outcomes that are reasonable to expect for this care. There are a variety of different ways to approach that care; we need to shift our emphasis therefore in regulation away from the structure and process fixation onto much more looking at the ratio of achieved to expected outcomes. For those outcomes can be expressed along a multiplicity of dimensions that include the full range of functioning, weighted by a careful assessment of what we really value among those multiple applications.

And, indeed, we need more dialog to find what it is that people really want. As we begin to talk about those things, it turns out there is much more consensus than we ever really expected existed. But there are also some very real differences among the different kinds of people who receive long-term care.

This kind of outcomes approach then would allow us to make comparisons across modalities of care. We can then get away from the fixation on alternatives with efforts to use one form of care to displace another, and focus on creativity in care delivery. It also allows us greater flexibility in terms of the rewards and penalties that we can put on the providers of care, rather than simply having to argue that we either put them in business or out of business or try to fine them. We can in fact begin to pay more for better care. We can begin to match our desire for better quality with our willingness to pay for it. At the same time we need to be willing to pay less for poor care and to do something about improving their clients by either taking bad providers out of the marketplace or making some very dramatic changes in their behavior.

If we can begin to open up the dialog about long-term care by looking afresh at the core issue rather than simply tinkering at the margins while maintaining the now anachronistic structure that we created, I think there is some hope in America for doing a better job.

[The prepared statement of Dr. Kane follows:]

Rethinking Long-term Care

Robert L. Kane, MD
University of Minnesota School of Public Health

Material prepared for
the Bipartisan Commission Field Hearing
May 25, 1989

The spate of activity in proposing legislation to finance long-term care (LTC) recognizes the importance of this up to now neglected aspect of care. Despite the activity the efforts are both too early and too late. They are too late in the sense that the group most affected by LTC, the elderly, are now viewed as having received their share of society's largesse for the moment. The spotlight in health care has shifted to others seen to be in greater need, especially the uninsured and the very young. They are too early because this country responds best to crises and the demographic imperative has not yet peaked.

This hiatus provides a needed opportunity to examine more carefully just what this society wants from long-term care and how to get it in the American context. Attention needs to be directed to what we want not simply how to pay for it. In other words, we should be concentrating on how to buy more with the dollars we spend rather than just seeking ways to spend less.

Some of this society's desires from long-term care suggest universal concerns; others reflect special American values. High on the list is a concern about spreading the risk of paying for the service. Although we continue to toy with the idea of some form of private LTC insurance, most analysts conclude that some form of universal coverage is needed wherein government plays a central

role. But establishing some form of public/private partnership is very appealing to Americans who place a special trust in the marketplace.

We also want a system that allows the recipient of care choice, dignity and privacy. This goal is sometimes referred to as quality of life as distinct from quality of care. We want to maintain and support the central role of the family in care giving without imposing unrealistic strains on spouses and children. Studies over time and across countries repeatedly demonstrate that the family's central role is not abrogated by a stronger public role in underwriting the cost of LTC.[1] We want a system that fosters creativity in an area that cries out for more innovative ways of delivering care, but we want safeguards to prevent exploitation and mechanisms to rewards good results, expressed in terms of both improved quality of care and better quality of life. The current regulatory approach seems to stifle creativity by imposing often unproven professional orthodoxies.

Americans have become used to looking hopefully to Canada for lessons about better ways to organize and deliver health care. Indeed, one can learn useful lessons about how to address issues related to LTC, but they are not blueprints suitable for direct transfer to the United States. The Canadian experience has shown that it is feasible to provide universally available care at a reasonable and controllable cost. Moreover, there are substantial advantages to having a single payor.[2] Canadian LTC experience has shown that the scale of efficient operation may be as small as half a million people. There are several operational models in Canadian provinces that

offer useful examples for how such care can be organized and managed.[3,4] Finally, the Canadian experience has shown the importance of linking the acute and LTC sectors at policy levels of government in order to foster appropriate cost shifting and to encourage savings achievable through better coordination, but without merging the two components into a single programs at the operational level for fear that the acute care sector might devour the LTC resources in its appetite for ever-increasing support.

Proposals

Uncoupling nursing and home

What then might be done to reconceptualize LTC and offer some ways toward a better system of providing such care? A first step may be to revisit the touchstone of LTC, the nursing home. Uncoupling the nursing function from the housing function conceptually and operationally will offer new vistas in both operations and finances.

At the level of financing, there is an opportunity for a new type of public/private mix of funding. Rather than the more typical mixed roles with large deductibles or public contributions to private insurance, this approach incorporates a universal entitlement to publicly sponsored coverage for nursing and supportive services regardless of where the client lives. At the same time, the housing component can be reasonably expected to be covered by private funds, as has been customary in this country. Thus, the greater the individual's means, whether from savings or a private insurance policy, the more amenities that person can afford. There is then an

incentive to save for LTC because there is something desirable to buy with those resources. For those with inadequate resources a minimal level of residential accommodations will still have to be provided.

From an operational vantage point, the uncoupling of service and residence means that care can be provided in individualized packages more responsive to client needs. The client can conceivably remain in the same living situation as the intensity of care changes, the services expanding as the level of need increases.

There are already models that foretell this approach to care. The continuing care retirement community incorporates this idea into its conceptual base, although many operational programs simply allow for transition from one level of care to another as needs dictate. Assisted living centers have evolved to provide very innovative care for many functionally impaired persons in a more socially attuned residential environment.

It is easy to envision new partnerships between community care agencies and residential developers. The efficiency of the proposed approach requires that care provider's travel time be minimized. It will not always be feasible to guarantee that everyone needing LTC can remain in his or her own home. Rural areas pose a special problem in this regard and will require innovative, flexible solutions. Many older persons needing assistance may be well served by some form of communal housing, where this term signifies bringing together persons with LTC needs to achieve economies of scale, but in a setting that emphasizes the client's control over living arrangements.

Such a system of flexible service provision will require careful oversight. In general, case managers will be needed to assess the clients' functional needs and to authorize and enable appropriate services to meet them. Although the Canadian system has demonstrated that it is feasible and certainly desirable to operate a cost conscious health care system with no deductibles and co-payments, such an approach will not likely fare as well in as entrepreneurial a society as the United States. Even the Canadians have used some form of co-payment in LTC to offset the housing costs of institutional care. In this country case management alone would probably not suffice to keep some individuals from exploiting the system, or at least the fear of such exploitation might prevent adoption. Reasonable co-payments that did not too harshly threaten the large number of older Americans with incomes just above the poverty level may be an acceptable price to pay for universal coverage of LTC services.

Outcomes-based regulation

The second major component of the LTC reformation is a new approach to regulation. The acute care sector has already begun to recognize the need for more attention to the outcomes of care.[5] LTC should not be doomed forever to repeat the mistakes of acute care. Here is an area where LTC can leap ahead, especially because the conceptual links between its process and outcomes are so weak. LTC should place its emphasis on outcomes expressed as the ratio of achieved/expected. Ideally, payment for LTC should reflect this

ratio. Certainly regulatory activities should be built around this approach.

Outcomes must be expressed in the form of such a ratio because the natural course of most LTC is toward deteriorating function. Simply rewarding good outcomes essentially rewards the selection of clients. The programmatic goal is exactly the reverse. One wants to encourage agencies to take on the most needy clients. Hence, the rewards are given to those providers who achieve a better result than might be reasonably expected for a group of clients with similar characteristics.

Such an approach is not difficult to operate. Measures are available to reflect the basic components that most agree should be part of a multi-dimensional assessment of outcomes. These include: physiological function, basic self-care (activities of daily living and instrumental activities of daily living), cognition, affect, social function (both activities and interpersonal relationships), and satisfaction with care and environment.[6] Such data can be collected directly from clients or they can be collected by the caregivers. Once gathered the baseline information can be employed in statistical calculations to produce expected outcomes and the actual outcomes (collected at a subsequent time after baseline) compared to them.[7]

Although there is some fear that having the providers collect this will lead to distortion, the nature of the approach makes gaming hard. Some independent validation will be necessary but the advantages are cost savings and a more proactive climate. The goal for an outcomes approach should be to facilitate a climate of continuous improvement.[8] Care providers should use the assessment

data to build meaningful care plans that reflect realistic expectations. Moreover, providing caregivers with information against which to compare their clients' progress offers a mechanism for improving job satisfaction in an environment where otherwise the workers see primarily declining function despite their best efforts.

One of the important corollaries of this approach is the need to reduce the multiple measures to a single summary measure. This step involves weighting the individual items on the basis of their social value. The process of assessing the value preferences for various states in LTC across these measures can itself produce very valuable discourse about what is truly wanted from such a system. Using a simple instrument to assess the value preferences from a variety of groups including those giving LTC, those receiving it, their family members, policy makers, regulators, and the general public, investigators have revealed a high level of consistency among the groups and that they place much higher values in general on patients who are physically impaired than on those who are cognitively impaired. Moreover, there are states valued worse than death.[9] No single set of value measures need suffice. The approach should be sufficiently flexible to permit recalibration for different groups. Indeed, the process of examining one's values about such care, especially engaging policy makers in such an exercise, dramatically alters the nature of the discourse about what is needed in LTC.

The ratio of achieved/expected outcomes for the summary measure can then be used to reward or penalize care providers. Those who consistently achieve results better than expected can receive either public recognition (in the hopes of stimulating a more

informed purchasing public) or cash bonuses; whereas just the reverse should pertain to those achieving consistently suboptimal results. These providers may bear closer scrutiny and perhaps remedial assistance or harsher steps.

The important corollary is that the providers operating under such an outcomes oriented approach be freed from much of the current regulatory straitjacket. (It will likely be necessary to maintain the life-safety regulations given our society's catastrophobia.) The social contract with care providers is changed to one that encourages creativity with accountability and permits comparisons across modalities of care, because the emphasis is on outcome rather than structure and process.

LTC corporations

The organization of LTC will likely require some form of capitation. No other mechanism provides the means to control overall costs and the political advantage of distancing the politician from the inevitable rationing decisions that must be part of an operational program in an area where the potential demand for services is so high. The Canadians have largely relied on public groups, often formed around local health departments or other social agencies, to take on this function with at least the semblance of capitated (or at least fixed) budgets based on prior spending patterns.

In this country, there have been proposals for capitated quasi-governmental corporations to oversee the LTC programs in geopolitically defined areas.[10] The difficulty such community-wide

systems face is the already large commitments to extant institutions, especially nursing homes. The recent experience in developing community care Medicaid waivers offers some basis for hope that careful planning and political will can shift resources toward a more flexible approach with time. On the other hand, it is unrealistic to expect that such community corporations can become effective without the infusion of at least some new resources. These funds at least can be directed toward the more flexible models of care described above.

The Canadian experience and common sense suggest that these corporations can cover long-term care without tackling acute care as well. Such a separation will provide some measure of protection from being subsumed but will also make it more difficult to encourage the mutual activities that may lead to true savings. Areas like geriatric assessment prior to placement might be funded under LTC auspices, but primary care for LTC recipients will continue to come from the acute care sector. The responsibility for encouraging effective coordination will have to rest with some superagency at the next higher level of government, where the incentives for overall cost-saving efficiencies will be appreciated.

Conclusion

America is known internationally as the land of the demonstration project. Ironically, other countries profit from the lessons derived from our careful testing of various delivery models. Our problem has been too many demonstrations and too few programs. We will do well to think carefully about what steps will

bring us closer to achieving the kind of LTC we want for our parents and ourselves. The demographic pressure provides an opportunity for creativity. Although we can learn much from the experience of other countries, the solution that works in America will have to be uniquely American.

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Chairman DURENBERGER. Great. Thank you, Doctor, very much. [Applause.]

The final panelist on this panel is Cynthia Polich of Interstudy.

STATEMENT OF CYNTHIA POLICH, PRESIDENT, INTERSTUDY

Ms. POLICH. Thank you Senator. One of the century's greatest achievements is the——

Chairman DURENBERGER. Pull your mike up.

Ms. POLICH [continuing]. Is the tremendous improvement in life expectancy that we have experienced. A child born in 1900 could expect to live about 48 years. A child born in the 1980's in contrast has a life expectancy of 70 years, if a boy, and almost 78 years, if a girl.

Due to this increased longevity and an associated decrease in fertility rates there has been an unprecedented increase in both the number and the proportion of people over age 65. Increases in the number of people over age 85 are particularly spectacular. And it's expected that the number of people in this age group will increase more than 8 times between 1980 and 2050 while their proportion of the total population will increase from 1 percent to over 5 percent.

One of the century's greatest challenges is to determine how best to pay the long-term care costs associated with this aging population. Today nearly $50 billion is spent in the United States for long-term care. The primary funding sources are out-of-pocket payments by those who use services and Medicaid for those who are poor or become poor due to their need for long-term care.

The cost associated with both public and private expenditures have climbed tremendously in the last decade and future increases are expected to be even more dramatic. By 1995 long-term care costs are expected to reach $80 billion nationally. But despite the billions of dollars that we spend on long-term care, the system is notorious for its inadequacies.

In addition to the high and rising costs, publicly funded services are largely limited to acute and institutional care. Inhome supportive services, as we have heard today, are needed by many elderly who suffer from chronic conditions but are inadequately covered. There is little or no coordination of medical and nonmedical services although such coordination is essential to provide an appropriate quality of care.

The funding sources are fragmented and uncoordinated resulting in inefficiency and confusion by those people and their caregivers who are seeking care. Finally, individuals must impoverish themselves to receive public assistance for nursing home costs.

What, if anything, can be done to improve this system? For nearly a decade the problems associated with long-term care and financing and delivery have largely been ignored. This is quickly changing, however, as consumers, policymakers, insurers, and providers become increasingly aware of the flaws and costs of our current system.

Numerous proposals are being developed to improve the long-term care financing system. Unfortunately, most of them seem to focus more on who will pay rather than what should be done.

One approach is to stimulate the private sector to pay for a greater proportion of long-term care costs. Typically, this approach means encouraging the proliferation of private long-term care insurance policies. Proponents of long-term care argue that relying on these policies is necessary because Government simply cannot afford to fund long-term care.

In contrast, some promote a long-term care system that is fully funded by the public sector. Proponents of this approach argue that the Federal Government is the only entity that has the opportunity to use the entire population as a risk pool for insurance purposes, thus minimizing program costs and individual premiums. The case has also been made that a public sector approach would provide greater access to services in a way that does not burden the frailest and poorest elderly in our society.

Interstudy, after 2 years of study funded by the Pew Charitable Trust, has recommended that the Federal Government take responsibility for financing long-term care through the development of a modified social insurance program that would be comprised of a Medicare Part C. We have provided a more detailed description of our proposals to the members of the Commission.

There are many reasons why we believe this approach is preferable to private financing of long-term care. One of the primary arguments against public financing of long-term care is fundamentally flawed. Proponents of private financing contend the public sector is incapable of allocating more funds for long-term care, given the deficit and related budgetary restraints. As a Nation, however, we are already paying the costs of providing long-term care, and we will continue to pay these costs far into the future. Whether public or private, the money that is generated to pay for long-term care is ultimately private money. It comes from individuals who disburse it through various forms of payment: Taxation, insurance premiums, direct out-of-pocket payments to health care providers. The private sector will not be able to manufacture resources that the public sector cannot draw upon. The question is, which method of generating revenue and disbursing benefits is most cost-efficient, equitable, and politically palatable.

In addition, it has been established that private financing will be available to a relatively small proportion of the population. The Brookings Institution, for example, has projected that only 20 percent of future elderly will be able to afford comprehensive, private long-term care insurance. As a result, public financing will continue to be needed, and, more importantly, the public sector will maintain responsibility for the sickest and poorest individuals resulting in a more costly public system.

It is only through a universal social insurance approach that the risk of long-term care can be pooled across the entire population and per capita cost minimized. It's only through this approach that administrative and marketing costs can be minimized and the vast majority of resources be allocated to direct services. It's only through a public program that we can avoid a two-tiered system that discriminates against the poor and sick while providing much greater benefits to the economically advantaged.

The issue of how to fund long-term care needs of the elderly has entered the forefront of public policymaking, and we all applaud

that. Already numerous bills have been introduced to Congress to resolve this problem. And in the next several years various approaches will be debated and some action will be taken. In the meantime, while we debate the merits of public versus private financing of long-term care, millions of elderly are currently at risk of impoverishment and unsuitable care because of a failing long-term care financing system. The needs of those elderly cannot be set aside by ignoring the need for an improved public system.

Thank you. [Applause.]

Chairman DURENBERGER. On behalf of the Commission, let me thank all three of you for that well articulated and deep commitment to the future of long-term care.

Our final panel will give us the Minnesota experience with long-term care in the person of LaVohn Josten who is the director of the public health nursing section at the Minnesota Department of Health and president of the Association of the State and Territorial Directors of Nursing.

Dale Thompson, president of Health Dimensions, Inc., vice president of region 5 of the American Health Care Association, and past president of the Care Providers of Minnesota.

Gayle Kvenvold who is the president and chief executive officer of the Minnesota Association of Homes for the Aging, and member of the advisory committee for the Geriatric Research, Education, and Clinical Center, a past president of the Minnesota Gerontological Society.

And Rich Bringewatt who is senior vice president of Altcare, former director of community affairs and associate director of services for the elderly at the Wilder Foundation.

We thank all of you for being here with us today. And, LaVohn, we will begin with your testimony.

STATEMENT OF LaVOHN JOSTEN, DIRECTOR, PUBLIC HEALTH NURSING SECTION, MINNESOTA DEPARTMENT OF HEALTH

Ms. JOSTEN. Thank you, Senator Durenberger. I would like to thank you for this opportunity to describe——

Chairman DURENBERGER. You need to grab the microphone.

Ms. JOSTEN. I would like to thank you for this opportunity to describe the Minnesota experience, because I think we have some good examples to share with the Nation.

I would like also to point out that I agree with what Dr. Kane says, that we need to think about the long-term care system in the current ways that we think about payment for the acute care system. We need to focus on how we can have a coordinated, individualized care system that the individual has some voice in.

And I would like to share with you information about three communities in Minnesota that have developed long-term care systems that enable people to care for themselves and that give them a voice in decisions that affect their care.

The Aitkin County Board of Commissioners endorsed in 1984 formation of a task force to plan for improvements to the existing long-term care service system. Members of that initial committee included people from the hospital, from the county commissioners, the board of health, the public health nursing agency which is the

certified home care agency in the community, other community agencies, and representatives of the senior population. A service and needs assessment inventory was administered to key informants.

As a result, a plan called building our future was developed. It addressed gaps in the service continuum, the need for coordination of service at the client and systems level, and congregate housing. As a result, care coordination has increased. More congregate housing is available in that community. A respite care program was initiated. Nutrition sites became available in the rural parts of the county. An RSVP Program was initiated. And their current effort is focusing on the feasibility of establishing adult day care in their community.

The Aitkin County long-term care task force is advisory to the county commissioners who are the payers of last resort in reference to long-term care. The citizens through their participation on the board, the committees, as well as its volunteers, and as voters have been able to have a voice in the decisions in their community that affect long-term care and that affect them.

This approach to long-term care planning is not unique to Aitkin County. In Winona County in 1985 the county commissioners also formed a task force which consisted of many of the same providers as well as representatives and community leaders. They addressed the issue of the needs of the frail elderly in their community.

As a result of that effort, today they have a central point of entry to the long-term care system which also provides information and referral services to people in need of long-term care. They have increased the amount of transportation available. Providers are coordinating their individual organizations' program planning in terms of new initiatives and the care provided to individuals. Care planning coordination has increased.

These initiatives are also occurring in the metropolitan area. The St. Anthony Park Block Nurse Program was started by a group of women in the St. Paul community who wished to develop a system of long-term care so that their neighbors could stay in their homes. A citizen board was established to guide the development of a system that provided the use of volunteers, volunteer nurses, and neighborhood nurses, and, through contract, public health nurses from Ramsey County Nursing Service. The latter oversee the home health assessment and care planning plus obtain any possible third-party payment. Evaluation data suggest without this program the majority of the clients served would be in nursing homes at significantly greater cost to the community.

Another rural county initiated a similar process as Aitkin and Winona, but they were unable to go forward because of lack of dollars. They needed dollars to expand their administrative staff and carry out the planning process, expand existing services such as the Public Health Nursing Home Care Program, and hire someone to recruit, train, and support volunteers, as well as cover the increasing cost of uncompensated care.

Another problem is Federal and State reimbursement policies which are designed for the acute home care rather than for long-term care. A current example of a Medicare requirement that's increasing cost in Minnesota is that for the long-term care mainte-

nance person that the frequency of nursing supervisory visits to the home health aide who is providing the bath is increased. This means the cost to the counties are increased and adds to the nursing shortage.

These are amongst the many reasons some communities have not initiated long-term care planning. They need help with these problems.

Other forms of help needed include training, technical assistance, and incentives to community to establish long-term care systems, and increased funding to pay for uncompensated care.

The programs I have described all facilitate individuals and their communities caring for themselves. Communities and county government are like the elderly individuals. They want to be able to care for their citizens. They, like the individual, need assistance for that to occur.

Thank you.

[The prepared statement of Ms. Josten follows:]

TESTIMONY BEFORE THE UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

by

LaVohn Josten, RN, Phd
Director, Public Health Nursing
Minnesota Department of Health

Public health in Minnesota has a long history of enabling people to care for themselves. It has also developed systems that facilitated those who are affected by public health programs, to have a voice in the decisions that affect their lives.

I would like to share with you information about three communities that have developed their long term care systems in a way that enables people to care for themselves and that gives them a voice in the decisions that affect their care.

The Aitkin County Board of Commissioners endorsed in 1984, as part of the Arrowhead Regional Development Commission's Long Term Care Project, the formation of a Task Force to plan for improvements to the existing long term care service system. Membership originally included representatives of the Aitkin

Community Hospital, the Board of County Commissioners, the Health Board, the Public Health Agency (which is the Certifed Home Care Agency), the Family Services Agency, the Committee on Aging, the Hospice Program, the Needs Steering Committee, the Housing and Redevelopment Authority and senior representatives. A service inventory and needs assessment survey was administered to key informants in the county. The resulting planning centered on:

1. Gaps in the service continuum
2. Coordination of services at the client and system level
3. Congregate housing

As a result a long term care plan for Aitkin County entitled "Building Our Future" was developed. Based on the plan the following has been achieved:

Care coordination has increased
More congregate housing is available
A respite care program was initiated
Nutrition sites became available in the rural parts of the county
An RSVP program was initiated
The feasibility of establishing adult day care is being studied

The Aitkin County long term care task force is advisory to the county commissioners, who are the payers of last resort. The citizens through their participation on the board, committees, as

volunteers and as voters have been able to have a voice in the decisions in developing a long term care system that meets the unique needs of Aitkin County.

The approach to long term care planning in Winona County was quite similar to Aitkin County. In 1985, the county commissioner convened a task force comprised of the public health agency, the home care and nursing home providers, hospitals, mental health and community leaders to address the needs of the frail elderly in their community. As a result the following has occurred:

1. A central point of entry to the long term care system has been established which also provides information and referrals
2. transportation services have been expanded
3. providers are coordinating their individual organizations program planning and the care provided to individuals

The St. Anthony Park Block Nurse program was started by a group of women in that St. Paul community who wish to develop a system of long term care so their neighbors could stay in their home. A citizens board was established to guide the development of a system that combines the use of neighborhood volunteers, neighborhood nurses and through contract public health nurses. The latter oversee the home health assessment and care planning plus obtain any possible third party payment. Evaluation data suggests without this program, the majority of the clients served

would be in nursing homes at significantly greater cost to the public.

In 1988, the Aitkin County program received one of 13 National Community Achievement Awards from the National Agency on Aging. The Block Nurse Program has received numerous national awards including funding from the Kellogg Foundation and the Division of Nursing of the U.S. Government for replication of their project.

Another rural county initiated a process similar to Aitkin and Winona. They convened a group of providers and citizens. They identified the gaps in services but were unable to go beyond that because they lacked the dollars to:

Expand their administrative staff to carry out the planning process
Expand existing services such as the Public Health Nursing Home Care Program to provide 7 day a week, 24 hour care
Hire someone to recruit, train and support volunteers

Federal and state reimbursement policies which are designed for acute and not long term care are another problem for all these community efforts. A current example of the latter is the Medicare requirement that home health aide visits to individuals receiving long term maintenance care must have the same frequency of nursing supervision as for the acutely ill. This means a home

health aide providing a routine bath to a frail, elderly woman needs the same level of nursing supervision as if the woman was 60 and recovering from cardiac surgery. This increases county cost since Medicare does not pay for non-acute care and adds to the nursing shortage.

These are amongst the many reasons some communities have not initiated any long term care planning. They need help with these problems. Other forms of help needed include training and technical assistance to the community leadership in forming community coalition, incentives to communities to established long term care systems and increased funding to pay for the services of those unable to pay.

The programs I've described all facilitate individuals and their communities caring for themselves with the support and assistance of numerous sources of funding. Communities and county government are like the elderly individuals, they want to be able to care for their citizens. They, like the individual, need assistance for that to occur.

Chairman DURENBERGER. LaVohn, thank you very much. [Applause.]

Now Dale Thompson. Thank you for being here.

STATEMENT OF DALE M. THOMPSON, PRESIDENT, HEALTH DIMENSIONS, INC.; VICE PRESIDENT, REGION 5, AMERICAN HEALTH CARE ASSOCIATION

Mr. THOMPSON. Thank you, Senator, for the opportunity to testify this morning. The long-term care providers that I represent look forward with great enthusiasm for the Commission to sort of grab this very difficult problem by the horns, and, as someone said earlier, see if we can't make something happen after many years of discussion.

Chairman DURENBERGER. Weren't you on an advisory committee to the last Secretary of HHS on this subject?

Mr. THOMPSON. We had a policy committee that looked at long-term care financing options and specifically long-term care insurance. Many of the comments I will make today are as a result of some of that discussion.

We would also like to thank you for your continuing leadership in this particular issue and look forward to future results.

The problem of how to finance the delivery of comprehensive long-term health care services is a very, very complex and broad-based problem. It's one that has to be addressed. We have to address it in order to pull together the fragmented array on long-term care services in this country and be able to offer them to seniors and others in somewhat a coordinated fashion.

As a spouse of one of the nursing home patients in our facility said to me a while back, there has got to be a better way to pay for long-term care in this country than to spend everything you own and go on welfare. And when you think about that, that's a very limited option especially for nursing home care and for other services. That indeed is the challenge before us.

I think there is a growing consensus in contrast to maybe what Cindy said earlier, that possibly a public-private approach might be one solution to looking at the solution to the comprehensive financing system for long-term care. I think there are resources in the private sector that need to be tapped. We see long-term care insurance. There are now 13 approved long-term care insurance policies in the State of Minnesota that meet the expectations of the legislature and other policymakers here.

And it's an effort to harness, if you will, some of the private sector resources. As someone mentioned earlier, half of the cost of long-term care today is paid for out-of-pocket. So we already are spending the money. And to the extent that we can harness some of those resources in more of a risk pooling fashion, that indeed there maybe is a private sector, if you will, part to the solution.

But I guess we also believe that not everyone can afford some of the options that will be developed in the private sector, and, indeed, we do need a public sector approach, if you will, also that can work in tandem with a private sector approach to get the best of both worlds, if you will, in trying to address the problem.

A second point I'd make, I guess, if we are going to look at a total public approach or a total private approach or some combination of the two, I think it's important to see where the commitment in the public sector comes now for paying for long-term care. In the case of nursing home services, we know that just under half the cost of nursing home care is paid for by the Medicaid Program in this country. The Medicaid dollars across the country are approximately half Federal dollars and half State dollars. As we look for public dollar commitments to fund whatever approach we end up with, it's important, I think, to retain the commitments that we have at this point because it would be difficult enough looking for new public commitments for funding, be it tax increases or other types of public commitments to fund whatever the solution is going to be.

One specific thing that we see happening is with the States' commitments to Medicaid. Again, about half the cost of Medicaid is paid for by the States. Last year's Medicare catastrophic proposal expanded the coverage for nursing home services under the Medicare Program. What we see happening is an expanded utilization of Medicare benefits in nursing homes. That has the effect then of having the Medicare Program paying for more days of nursing home care. It lessens the burden, if you will, on State Medicaid budgets, and we see in all the State legislatures across the country Medicaid savings being realized in various State legislatures because of the expanded Medicare dollars.

Now, what many people had thought is if we develop a Medicare Part C Program, indeed then we have to worry about a reduced level of support on the part of the States. But in Minnesota, for example, the State cost of nursing home care has been reduced approximately 10 percent just this year for the next 2 years alone by the expanded payment for services by Medicare.

And I would suggest to the Commission that when they find the ultimate solution, whether it's all public or all private or some of each, that we will probably need all the public commitment that we have at this point, and they should wrestle with the problems that, if the States are going to be involved in some of this public commitment, they need to continue to share at least the level of responsibility that they're sharing now. Because the Federal Government may not be able to take on the whole public sector commitment.

Finally, I guess I would say that I'd urge the Commission not to be timid. I think various surveys that have been looked at, a recent one by the Villers Foundation showed that by a 5 to 2 margin respondents expressed a willingness to tax themselves or to pay in some other way for long-term care services, one of the few needs in this country that people have stepped forward and said they're willing to make a commitment to fund.

So I would again urge that the Commission and Members of Congress, when they receive the report, to take action, as someone suggested earlier, and to make the commitment to an aggressive program for the future.

Thank you.

[The prepared statement of Mr. Thompson follows:]

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May 25, 1989

Dale M. Thompson
VICE PRESIDENT, Region V
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Mr. Chairman, my name is Dale Thompson, President of Health Dimensions. We are a long term care provider of skilled nursing home services, senior housing options, assisted living and home care services here in Minnesota.

I am a past president of Care Providers of Minnesota and am currently serving as Regional Vice President for the American Health Care Association whose membership is comprised of in excess of 9,000 long term care facilities caring for 900,000 nursing home patients on a daily basis. I recently served as a member of the Department of Human Services Task Force on Long Term Health Care Policy charged with reviewing long term care financing options including long term care insurance. I believe our final report to the Congress contains some valuable insight into the problems the commission is charged with addressing and would urge you to review its findings.

My comments as part of this panel will be directed toward the commissions charge of developing specific recommendations regarding: "financing needed to assure the availability of comprehensive long term care services for the elderly and disabled."

The problem of how to finance the delivery of comprehensive long term care services in the country is broad based and complex. It is a problem that must be addressed however before we can hope to bring together a very fragmented array of long term care services and make them accessible and affordable to a rapidly growing elderly population and a younger and disabled population as well.

A non-profit organization of proprietary and non-proprietary long term health care facilities dedicated to improving health care of the convalescent and chronically ill of all ages. An equal opportunity employer.

I believe there is a growing concensus that the problems related to providing long term care benefits can be addressed most effectively through a partnership of public and private efforts. The private sector clearly can do more than it is doing now, but it will never be able to completely take care of the long-term support needs of individuals already 85 years and older, people currently suffering from chronic illness and low-income persons who cannot afford any private coverage. A public/private approach that incorporates innovative private sector solutions for those who are able to pay for them while retaining and improving public programs to protect those who will continue to rely on them will likely be the best solution in the end.

In this context I would offer the following specific comments for your consideration:

1) LTC Insurance is a significant and important part of financing the future delivery of services. It is important I believe to understand that finding oneself in a position of needing long term care services on a permanent basis or for a short, well defined period of time is an insurable event. We are able to purchase insurance coverage for virtually all other health care needs. We need to be able to do the same for long term care also. The LTC insurance market is in its infancy but the quality of products continues to improve as does their affordability.

There are now over 100 companies with products on the market with the number of policies sold doubling each year. Federal and state governments continue to explore ways of encouraging the development and sale of good policies. The commission should seriously consider options such as tax incentives to purchase long term care insurance policies, expansion of medicaid/medicare eligibility and benefits for those who have insurance, re-insurance programs to support private insurance efforts and reduce the ~~rush~~ risk of

developing new products. Approaches such as the "2 year stop loss" offered last year in the Senate should be considered also as a more comprehensive approach to more formally bring together public/private effort.

Employment based insurance programs and incentives to purchase coverage at a younger age would enhance the risk pooling necessary to developing adequate and affordable policies.

2) Public Funding Efforts - As the commission strives to reshape and refocus public dollar funding for long term care, they should be careful to not lose current funding commitments by federal, state and local governments. The primary source of public funding for nursing home care has been and continues to be the medicaid program. At any given time, approximately 60-70% of Minnesota nursing home residents receive some assistance in paying for their care from medicaid and the medicaid program provides slightly less than 50% of the total cost of nursing home care.

About half of all medicaid funding is provided by the states. We are already seeing this commitment of existing funding eroded significantly by the recent expansion of medicare under the Medicare Catastrophic Act of 1988 and the change in intermediary policy.

State legislatures across the country this year are using increased (all federal money) medicare revenues to nursing homes to reduce their state medicaid funding of these services. In many cases these dollars are being redirected toward other budget balancing concerns.

If the state funding of long term care services continues to decline it will create a larger price tag for the federal government part of any public sector solution. It will be very different to "reinstate" a funding commitment from the state once they have redirected current budget funding.

3) Public Support for LTC Financing - Numerous studies continue to show that the public will support and pay for additional funding for long term care. It is one of very few issues voters are willing to spend more money on, increasing their own tax burden.

A recent Villers Foundation study showed that by a 5-2 margin, respondents expressed willingness to tax themselves at rates which correspond to their income to pay for long term care. Much of this support comes from concern for their ability to provide for the care of an older parent and difficult choices such as caring for an older parent versus providing for the education of ones children.

A payroll tax beginning at age 40 or 50 might be a possible source of financing for long term care services. It is at this age that people enter their highest earning years in terms of annual salary and the time when they begin to face the need to care for older parents and planning for their own retirement years. To the extent that increased revenues and medicaid reductions contributed to solving the budget deficit it might generate the support needed for enactment.

4) Current Medicaid Reimbursement of Long Term Care Services- The design, delivery and payment for long term care services is currently driven by a very fragmented system of fifty state medicaid plans and reimbursement rules.

This would be a bad system to emulate in a new public/private approach. We need creative and innovative approaches to the design and delivery of future long term care services. Appropriate levels of funding to accomplish the evolution of our long term care system usually falls victim to the budget cutting priorities of 50 state legislatures as they meet each year. Reimbursement systems are complex and not easily understood by legislators let

alone attempting to discuss these technical and complex systems in the context of the legislative arena.

A consolidation of coverage of LTC services into the medicare program while not losing current state medicaid funding appears to be a commonsense approach to eliminating the fragmentation and "welfare" approach that the current medicaid system promotes.

Thank you very much for the opportunity to testify today. I would be happy to answer any questions you might have about my comments.

Dale M. Thompson, President
Health Dimensions, Inc.

Chairman DURENBERGER. Great. Dale, thank you very much. [Applause.]

Now Gayle Kvenvold.

STATEMENT OF GAYLE M. KVENVOLD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MINNESOTA ASSOCIATION OF HOMES FOR THE AGING

Ms. KVENVOLD. Thank you, Senator.

As nonprivate providers, we have been the active, if not always willing, participants in the reform policy that Sandra Gardebring described earlier. There have indeed been successes in Minnesota in cost containment and in the expansion of the continuum. Nursing home occupancy continues to climb here in the State in spite of tight controls on the supply. Savings in the State Medicaid budget have been considerable. And, most importantly, we have introduced some new options for consumers.

There have also been some unintended consequences of all of this change. The nursing home industry in our State is in serious financial difficulty. In the current rate year, we project revenues over expenses for nursing homes in this State of just $131,000, on anticipated operating revenues of $650 million. That translates to an operating margin of less than two one-hundredths of 1 percent.

The industry is replete with stories of homes spending reserves and borrowing money—in some cases to make payroll and in other cases to avoid compromising our longstanding commitment to quality of care. A combination of things has created this situation including some design flaws in the reimbursement mechanism of our State casemix system and spiraling labor costs fueled by an intensifying nursing shortage.

But my message to you today is that we still rely on nursing homes to meet the long-term care needs of a portion of our elderly population. And in spite of our program advances those nursing homes remain heavily dependent on Medicaid. And the use of Medicaid means that the people in those homes must impoverish themselves to get the care they need. This is not a situation unique to Minnesota, but perhaps nowhere is this dependence better illustrated since we are the only State which statutorily limits the private pay rate to the Medicaid rate.

There is no cost shift to other payers. And this fact serves to underscore the pressure States are under to adequately fund the Medicaid Program. And the dilemma that we face as providers is trying to respond to rising consumer expectations in the context of a reimbursement and a regulatory system that financially rewards efficiency but has no similar incentive for quality or innovation or creativity. I don't believe we can talk about the establishment of a comprehensive long-term care system without addressing that dilemma.

A part of the answer may lie in stimulating private resources. But, in addition, I think we need to look to changes that are under way to reshape the health care delivery system along the lines of what Dr. Kane discussed.

The role of the nursing home in the continuum has changed. Here in Minnesota the number of admissions and discharges to fa-

cilities increased by nearly 10 percent over the last 2 years. But the average length of stay declined by 25 days. More and more homes find themselves caring for persons in one of two categories. First of all, those people who stay for a relatively short period of time for rehabilitation or respite or terminal care, and those numbers are increasing. And, second, those persons whose length of stay is longer and may be described as among the oldest or most frail or impaired or those without the kind of family support we heard so eloquently described this morning.

As you look at long-term care programs and financing, incentives should be created for greater emphasis on care in that first category. However, it's vital to recognize that the real catastrophic nature of long-term care costs for both the consumer and the provider lie in the second category of care. It's also these residents who are the least likely candidates for alternative services as we know them today.

As we look at our current reliance on medical assistance I will echo some of Dale's words and his comments to what we see happening with Medicare in Minnesota. I had the opportunity 1½ years ago to testify before you, Senator, and I said that Medicare was not a long-term care program. And while that may still be true, we have seen some dramatic changes.

In 1987 Medicare utilization in Minnesota accounted for less than 1 percent of all resident days. In 1988 that figure grew to 3 percent. And by 1991, we expect total resident days covered by Medicare to be 16 percent of resident days in Minnesota. These improvements can be traced largely to the improved coverage guidelines but also to the Catastrophic Health Care Act. This is great news for consumers. And savings also accrue to State Medicaid budgets.

We do have a significant problem to work out on behalf of providers in Minnesota that's caused by a lack of interaction between the Federal Medicare Program and our State Medicaid Program, but the thought I'd like to leave you with is this: That as the Federal Government gets the bill for these increased services under Medicare, I do hope we won't see an erosion of the progress that we have made to this point. Rather, I hope that we might be able to create the kind of momentum needed to develop a restructured Medicare Program that would embrace the full range of long-term care services and the kind of social insurance approach described by Grace Nelson.

Finally, while most of us as providers trace our roots to nursing home services, we are increasingly involved in senior housing options, adult day care, respite care, caregiver support, and, more recently, assisted living. So I would say to you that we stand ready to work with you not as part of the problem but as part of the solution to comprehensive long-term care.

Thank you very much.

[The prepared statement of Ms. Kvenvold follows:]

Testimony of

Gayle M. Kvenvold

President and Chief Executive Officer

Minnesota Association of Homes for the Aging

to the

U.S. Bi-Partisan Commission on

Comprehensive Health Care

May 25, 1989

I'VE BEEN ASKED TODAY TO ADDRESS LONG-TERM CARE FROM THE PROSPECTIVE OF THE PROVIDER OF SERVICES AND PROGRAMS AND IN DOING SO I WILL DRAW HEAVILY ON THE EXPERIENCES OF THE NON-PROFIT PROVIDERS OF HEALTH CARE AND HOUSING HERE IN MINNESOTA. WHILE MOST OF US AS PROVIDERS TRACE OUR ROOTS TO THE PROVISION OF NURSING HOME SERVICES, WE ARE INCREASINGLY INVOLVED IN THE PROVISION OF SENIOR HOUSING OPTIONS, ADULT DAY CARE, HOME CARE, RESPITE CARE AND CAREGIVER SUPPORT, AND MORE RECENTLY, ASSISTED LIVING. OUR ABILITY TO BE INNOVATIVE AND RESPONSIVE TO THE NEEDS OF THE ELDERLY WE SERVE IS DIRECTLY RELATED TO OUR MISSION AND OUR TENACITY IN PIECING TOGETHER THE MAZE OF RESOURCES AND REGULATIONS THAT TODAY GO INTO THE PROVISION OF LONG-TERM CARE.

WE HAVE BEEN ACTIVE, THOUGH NOT ALWAYS WILLING, PARTICIPANTS, IN AGGRESSIVE REFORM OF LONG-TERM CARE POLICY IN MINNESOTA - THIS REFORM HAS BEEN AIMED AT CONTAINING NURSING HOME COSTS, ASSURING APPROPRIATE UTILIZATION OF SERVICES AND BROADENING THE CONTINUUM OF CARE AND WE HAVE HAD SOME SUCCESSES.

ALTHOUGH NURSING HOME EXPENDITURES REMAIN THE LARGEST PORTION OF THE STATE'S MEDICAL ASSISTANCE BUDGET, MINNESOTA HAS SUCCEEDED IN SIGNIFICANTLY REDUCING THE RATE OF GROWTH IN THIS BUDGET CATEGORY, IN ADDITION TO INCREASING AVAILABILITY OF HOME-BASED SERVICES AND HOUSING OPTIONS. NURSING HOME OCCUPANCY CONTINUES TO DECLINE EVEN WITH TIGHT CONTROLS ON SUPPLY AND ESTIMATES OF SAVINGS IN THE STATE MEDICAID BUDGET FROM ALL OF THESE CHANGES IS ESTIMATED TO BE AT LEAST $200-300 MILLION.

THERE HAVE ALSO BEEN SOME UNINTENDED CONSEQUENCES OF THESE POLICY INITIATIVES. THE NURSING HOME INDUSTRY IS IN SERIOUS FINANCIAL DIFFICULTY. IN THE CURRENT RATE YEAR, WE PROJECT A NET OPERATING MARGIN FOR THE ENTIRE INDUSTRY OF $131,000. BASED ON ANTICIPATED OPERATING REVENUES OF APPROXIMATELY $650 MILLION, THIS REPRESENTS LESS THAN .02%. THE INDUSTRY IS REPLETE WITH STORIES OF HOMES SPENDING RESERVES AND BORROWING MONEY, IN SOME CASES TO MAKE PAYROLL.

A COMBINATION OF THINGS HAS CREATED THIS SITUATION INCLUDING SOME DESIGN FLAWS IN THE REIMBURSEMENT MECHANISM OF OUR CASEMIX SYSTEM AND SPIRALING LABOR COSTS FUELED BY THE INTENSIFYING NURSING SHORTAGE. WE ARE TRYING TO WORK WITH STATE POLICYMAKERS TO REMEDY THIS SITUATION BUT MY MESSAGE TO YOU TODAY IS THAT IN SPITE OF OUR PROGRAM ADVANCES, WE REMAIN HEAVILY DEPENDENT ON NURSING HOMES TO MEET THE LONG-TERM CARE NEEDS OF THE ELDERLY AND THOSE NURSING HOMES REMAIN HEAVILY DEPENDENT ON MEDICAID. THIS IS NOT A SITUATION UNIQUE TO MINNESOTA BUT PERHAPS NO WHERE IS THIS DEPENDENCE BETTER ILLUSTRATED SINCE WE ARE THE ONLY STATE IN THE NATION WHICH STATUTORILY LIMITS THE PRIVATE PAY RATE TO THE MEDICAID RATE. THERE IS NO COST SHIFT TO OTHER PAYORS AND THIS FACT SERVES TO ILLUSTRATE THE DIFFICULTY STATES HAVE IN ADEQUATELY FUNDING A VERY EXPENSIVE HUMAN SERVICE AND THE DIFFICULTY WE HAVE AS PROVIDERS IN RESPONDING TO CONSUMERS EXPECTATIONS FOR A QUALITY SERVICE. I DON'T BELIEVE WE CAN TALK ABOUT THE ESTABLISHMENT OF A COMPREHENSIVE LONG-TERM CARE SYSTEM WITHOUT ADDRESSING HOW WE REDUCE THIS RELIANCE ON MEDICAL ASSISTANCE.

A PART OF THE ANSWER MAY LIE IN STIMULATING PRIVATE RESOURCES BUT IN ADDITION WE NEED TO LOOK TO CHANGES THAT ARE UNDERWAY TO RESHAPE THE SERVICE DELIVERY SYSTEM. THE ROLE OF THE NURSING HOME IN THE CONTINUUM HAS CHANGED DRAMATICALLY. THE NUMBER OF ADMISSIONS AND DISCHARGES TO MINNESOTA NURSING HOMES INCREASED BY NEARLY 10 PERCENT OVER THE PAST TWO YEARS AND THE AVERAGE LENGTH OF STAY DECLINED BY 25 DAYS. INCREASINGLY, HOMES FIND THEMSELVES CARING FOR PERSONS IN ONE OF TWO CATEGORIES: 1) THOSE WHO STAY FOR A RELATIVELY SHORT TIME FOR REHABILITATION, RESPITE OR TERMINAL CARE AND 2) THOSE PERSONS WHOSE LENGTH OF STAY IS LONGER AND MAY BE DESCRIBED AS THE OLDEST AND/OR MOST FRAIL OR IMPAIRED AND/OR THOSE WITHOUT FAMILY SUPPORT. FEW WOULD ARGUE THAT THIS EVOLUTION OF THE NURSING HOME IS NOT A POSITIVE DEVELOPMENT IN TERMS OF THE OVERALL CONTINUUM OF CARE AND AS YOU LOOK AT LONG-TERM CARE PROGRAMS AND FINANCING, INCENTIVES SHOULD BE CREATED FOR GREATER EMPHASIS ON CARE IN THE FIRST CATEGORY. HOWEVER, IT IS VITAL TO RECOGNIZE THAT THE REAL CATASTROPHIC NATURE OF LONG-TERM CARE COSTS FOR THE CONSUMER AND PAYOR LIES IN THE SECOND. IT IS THESE RESIDENTS WHO ALSO ARE THE LEAST LIKELY CANDIDATES FOR THE ALTERNATIVE SERVICES THAT EXIST TODAY.

AS THE ROLE OF THE NURSING HOME HAS CHANGED, ONE OF THE MOST EXCITING DEVELOPMENTS IS THE EMERGENCE OF THE CONCEPT OF ASSISTED LIVING. ALTHOUGH THERE IS NO UNIFORM DEFINITION, IN MINNESOTA THIS IS A CONGREGATE SETTING, USUALLY SENIOR HOUSING, WHERE A VARIETY OF SUPPORTIVE SERVICES ARE MADE AVAILABLE, INCLUDING A COMPONENT OF PERSONAL CARE. THERE ARE SEVERAL DIFFERENT MODELS

IN MINNESOTA AND AROUND THE NATION BUT MOST HAVE IN COMMON A LARGELY UNREGULATED INDEPENDENT LIVING ENVIRONMENT AND OFFER A GENUINE ALTERNATIVE TO THE OLDER PERSON WITH SUPPORTIVE CARE NEEDS WHO 5-10 YEARS AGO WOULD HAVE FOUND HIM OR HERSELF IN A NURSING HOME.

FINALLY, AS WE LOOK AT OUR CURRENT RELIANCE ON MEDICAL ASSISTANCE, I MUST COMMENT ON WHAT WE SEE HAPPENING IN MEDICARE IN MINNESOTA. A YEAR AND A HALF AGO I TESTIFIED TO THE SENATE SELECT COMMITTEE ON AGING THAT MEDICARE WAS NOT A LONG-TERM CARE PROGRAM. WHILE THAT MAY STILL BE TRUE, WE HAVE SEEN SOME DRAMATIC CHANGES. MEDICARE UTILIZATION IN SKILLED NURSING FACILITIES IN MINNESOTA ACCOUNTED FOR LESS THAT 1 PERCENT OF ALL RESIDENT DAYS IN 1987 OR ABOUT 90,000 DAYS OF CARE. IN THE FOURTH QUARTER OF 1988 ALONE MEDICARE ACCOUNTED FOR NEARLY THREE TIMES THAT MANY RESIDENT DAYS AND WE ARE FORECASTING AN INCREASE TO 2.4 MILLION MEDICARE DAYS OR 16% OF TOTAL RESIDENT DAYS OVER THE NEXT TWO YEARS. THESE IMPROVEMENTS CAN BE TRACED LARGELY TO THE 1988 CHANGES IN COVERAGE GUIDELINES BUT ALSO TO THE CATASTROPHIC HEALTH CARE ACT. THE SAVING FOR CONSUMERS AND THE STATE MEDICAID AGENCY WILL BE SIGNIFICANT.

AS PROVIDERS, WE ARE PLEASED TO SEE TANGIBLE MEDICARE BENEFITS FOR RESIDENTS AND PERHAPS WHAT APPEARS TO BE INCREASED COMMITMENT TO LONG-TERM CARE WILL HELP TO CREATE THE MOMENTUM NEEDED TO DEVELOP A RESTRUCTURED MEDICARE PROGRAM THAT WOULD EMBRACE THE FULL RANGE OF LONG-TERM CARE SERVICES IN A SOCIAL INSURANCE APPROACH. HOWEVER, IN THE MEANTIME I MUST CALL THIS ISSUE TO

YOUR ATTENTION: BECAUSE MEDICARE AND MEDICAID USE DIFFERENT PAYMENT APPROACHES AND BECAUSE MEDICARE FAILS TO MAKE ANY ADJUSTMENT FOR SEVERITY, MINNESOTA PROVIDERS LOSE APPROXIMATELY $12 PER DAY ON EVERY MEDICARE RESIDENT IN OUR HOMES. THIS SITUATION IN MINNESOTA IS MADE MORE URGENT BY OUR EQUAL RATES LAW AND OUR PRECARIOUS FINANCIAL POSITION, BUT SOME OTHER STATES ALSO SUFFER THIS LACK OF INTERACTION BETWEEN MEDICARE AND MEDICAID. IN THE LONG RUN, THIS MAY REINFORCE THE NEED FOR A CONSOLIDATED FEDERAL APPROACH TO LONG-TERM CARE FINANCING. IN THE SHORT-RUN, IT CERTAINLY CALLS FOR GREATER STATE AND FEDERAL COORDINATION AND FLEXIBILITY AT THE ADMINISTRATIVE LEVEL.

THANK YOU FOR THIS OPPORTUNITY TO SHARE MY THOUGHTS.

Chairman DURENBERGER. Thank you, Gayle. [Applause.]
Our final panelist, Rich, thank you for being here.

STATEMENT OF RICH BRINGEWATT, SENIOR VICE PRESIDENT, ALTCARE, BLOOMINGTON, MN

Mr. BRINGEWATT. As the final leg of this hearing today, I'd simply like to assert that the business of long-term care is entering a period of profound change without historical precedence. The population in need is expected to grow faster than at any time in history. And this is most clearly indicated by four factors. One, there is projected to be a sevenfold increase in the 85-plus population that is projected for the next 70 years while the overall population is projected to only increase by 50 percent. Two, we have a Federal deficit without historical precedence; yet there is not a public will to increase taxes. Three, the cost of health care continues to exceed the rate of inflation, in spite of cost containment; and older people and their families and professional providers are constantly being asked to do more with less. And four, the existing system of care is increasingly being viewed as inadequate and new solutions are yet to be found. With this context I would like to offer three overall recommendations.

One, the focus of policy planning needs to shift from issues of long-term care to issues of chronic impairment.

Two, new comprehensive national policy is needed to guide program activity across the spectrum of public and private financing for the chronically impaired elderly.

And, three, a long-range strategy of health care reform for the chronically impaired is needed to sequentially prepare for the newly emerging problems of the 21st century.

With reference to shifting the focus of policy planning from long-term care to problems of chronic impairment, it's important to keep in mind that, from a client's perspective, care involves far more than what is provided by nursing homes and home health agencies. Problems of the chronically impaired are volatile, complex, and ongoing. They require services from hospitals, physicians, family caregivers, and a host of other providers, in addition to nursing homes and community-based long-term care programs.

When public policy focuses only on a narrow segment of care and not on the totality of the problem to be addressed, the resultant array of services becomes fragmented, continuity of care becomes difficult at best, and no one can determine the full cost let alone control it. In order to be truly responsive to the chronically impaired, public policy must encompass the full array of client conditions and reflect how conditions are exhibited as a matter of priority. Comprehensive client-centered policy means focusing on issues of both care and cure, on issues of function and disease, on issues of the client's home as well as the nursing home, on issues of caregiver burden as well as the shortage of nurses, on enhancing relationships between people who provide support as well as perfecting professional competencies.

It means establishing care policy to include help from the time a person breaks a hip, first experiences mental confusion, or has a stroke, and maintaining support until functional recovery or death.

It means supporting the development of care networks where hospitals, physicians, nursing homes, home health programs, family caregivers, churches, and others who serve many of the same clients work together in addressing this multiproblem condition.

If it is the intent of the Commission to take a comprehensive view of long-term care, then it's critical to look at the problems of the chronically impaired in their entirety, to develop national policy which responds to the totality of those conditions, and to include care options that reflect how conditions are naturally exhibited, rather than how health care is traditionally practiced within a predefined provider set.

Four examples of program innovation that reflect this provider view are the Block Nurse Program which was previously discussed, the Alzheimer's Care Network, Elder Homestead, and the Minnesota-based social HMO called Seniors Plus.

The Alzheimer's Care Network is a program of the Wilder Foundation. It includes a restructuring of the full care continuum. Support is offered from the point the person first identifies loss of memory or confusion and maintains involvement throughout the duration of the illness. It covers all aspects of housing, health, and social services.

Elder Homestead is a dedicated assistance housing strategy that serves people at risk of nursing home placement, but it's not a nursing home. All residents have nursing-home-type conditions yet each resident only receives what he or she wants. Care and facility issues are under separate management, and each resident only receives and pays for the care that is appropriate for his or her needs.

Seniors Plus, the most well known of the four programs, is one of four social HMO's in the country designed to offer long-term care as an integral part of a total health care program. It seeks to work with older people and their families, whatever their conditions, and offers nonmedical long-term care benefits as well as hospital, physician, and nursing home benefits under a single computation.

In analyzing these program alternatives, it must be recognized that none of these programs would be able to function under their current forms if they were totally dependent on existing public financing and had to function under existing rules. They serve clients in ways that are natural and preferable and not in ways that are traditional. Part of the key to their success may be that those involved are more concerned with naturalizing professionalism than with professionalizing volunteerism, and they give priority to client needs rather than simply what Medicare will pay for.

In order to adequately respond to the emergent problems previously identified and in ways that respond to issues of both care and quality, it is extremely important that a national umbrella policy must be developed that covers the full spectrum of chronic care. This should include standardization of policy across all of the pub-

licly financed programs for the chronically impaired elderly and development of a single national change strategy for changing health care to adequately meet future demands. This policy and strategy must respond to how chronic conditions are naturally exhibited and, if necessary, fundamentally restructure how care is financed, administered, and delivered.

Thank you. [Applause.]

[The prepared statement of Mr. Bringewatt follows:]

UNITED STATES BIPARTRISAN COMMISSION ON COMPREHENSIVE HEALTH CARE: May 25, 1989 Hearing
Testimony by Richard J. Bringewatt, Senior Vice President, Altcare

My name is Richard Bringewatt, Senior Vice President of Altcare, a Minnesota-based company specializing in the design, development and application of program innovation in care of the chronically impaired elderly. Altcare was established in 1983 as a corporate-provider partnership between the Wilder Foundation and General Mills.

The purpose of my remarks is two fold: (1) to take a provider-based perspective and share with you several recommendations based upon my experience in developing LTC innovation and (2) to highlight several innovative LTC programs based in Minnesota.

First, as a matter of background, it is my belief that the business of long-term care is entering a period of change without historical precedence. The population in need is expected to grow faster than at any point in history. This is most clearly indicated by the seven-fold increase in the 85+ population over the next 70 years, while the overall population is expected to increase by only 50%. We have a federal deficit of major proportions without a public will to increase taxes. The cost of health care continues to exceed the rate of inflation, in spite of cost containment. And, older people, their families, and professional care providers are constantly being asked to do more with less. The existing system of care is increasingly being viewed as inadequate, and new solutions are yet to be found. Within this context I would like to offer three overall recommendations.

1. *The focus of policy planning needs to shift from issues of long-term care to issues of chronic impairment;*

2. *New comprehensive national policy is needed to guide program activity across the spectrum of public and private financing for the chronically impaired elderly; and*

3. *A long range strategy of health care reform for the chronically impaired elderly is needed to sequentially prepare for the newly emerging problems of the 21st century.*

With reference to shifting *the focus of policy planning from long term care to problems of chronic impairment*, it important to keep in mind that from a client's perspective, care involves far more than what is

provided by nursing homes and home care agencies. Problems of the chronically impaired are volatile, complex and ongoing. They require services from hospitals, physicians, family caregivers, and a host of other providers, in addition to nursing homes and community-based long term care programs. When public policy focuses only on a narrow segment of care, and not on the totality of the problem to be addressed, the resultant array of services becomes fragmented, continuity of care becomes difficult at best, and no one can determine the full cost of care let alone control it.

In order to be truly responsive to the chronically impaired, public policy must encompass the full array of client conditions and reflect how conditions are exhibited as a matter of priority. Comprehensive, client-centered policy means focusing on issues of both care and cure, on issues of function and disease, on issues of the client's home as well as the nursing home, on issues of caregiver burden as well as the shortage of nurses, and on enhancing relationships between all the persons who provide support as well as perfecting professional competencies. It means establishing care policy to include help from the time a client breaks a hip, first experiences mental confusion, or has a stroke, and maintaining support until functional recovery or death. It means supporting the development of care networks where hospitals, physicians, nursing homes, home health programs, family caregivers, neighbors, churches, and others who serve the same individuals can work together in addressing the multi-dimensional conditions of chronic impairment.

If it is the intent of the Commission to take a comprehensive review of long term care, then it is critical to look at problems of chronic impairment in their entirety, to develop national policy which responds to the totality of those conditions, and to include care options that reflect how conditions are naturally exhibited rather than how health care is traditionally practiced within a pre-defined provider segment.

Four examples of program innovation in Minnesota that reflect this broader view are the Block Nurse Program, the Alzheimer's Care Network, Elder Homestead and the Minneapolis-based Social HMO called Seniors Plus.

The Block Nurse Program is a neighborhood-based approach to keeping older people at home as long as possible. The program is managed through the local neighborhood council and involves extensive use of local residents serving in a volunteer capacity. It also includes health care services provided by or under the supervision of nurses who live in the client's neighborhood who follow a natural self-help, mutual-help approach.

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The Alzheimer's Care Network is a restructuring of the care continuum. Support is offered from the point a person first identifies loss of memory or confusion as a serious problem, with program staff staying involved throughout the duration of the illness. It covers all aspects of health, housing and social service needs and responds to the care needs of both the family and the person afflicted with the disease. In all cases, care is provided to supplement the involvement of a primary caregiver to optimize the personal well-being of both the caregiver and the Alzheimer's victim.

Elder Homestead is a dedicated assisted housing strategy that serves people at risk of nursing home placement, but it is not a nursing home. All residents have nursing home type conditions, yet each resident only receives what he/she needs and wants. Care and facility issues are under separate management, and each resident only receives and pays for the care that is appropriate for his/her individual needs. Maximum use is made of family, volunteers and neighborhood residents.

Seniors Plus, the most well known of the four programs, is one of four Social HMO's designed to offer long-term care as an integral part of a total health care insurance program. It seeks to work with older people and their families, whatever their condition may be, and offers non-medical home care benefits, as well as hospital, physician and nursing home benefits under a single financial capitation.

Other program innovation could also be identified that give more emphasis to integration of acute and long-term care programming but these four programs represent important innovative approaches to quality, cost-effective care. It must be recognized, however, that none of these programs would be able to function in their current form if they were totally dependent on existing public financing or had to function under existing rules and regulations. They serve clients in a way that is natural and preferable but not in a way that is traditional. Part of the key to their success may be that those involved are more concerned with naturalizing professionalism rather than professionalizing volunteerism. They give priority to what a given client needs and wants rather than simply what Medicare will finance.

Given this broader view, it is absolutely critical that a national policy umbrella be established to encompass the entire spectrum of public and private financing. People who are receiving long-term care services, as they are now defined, also frequently need benefits under Medicaid, Veterans benefits, the Older Americans Act, the Block Grant program under the Social Security Act, State funds,

private insurance, and a host of other programs. Each of these public and private programs often approaches care differently, and unless some semblance of order is brought to the spectrum of health care financing, developing a rational approach to long-term care at the local level will be almost impossible.

In looking ahead to the 21st Century, Congress should adopt an overall vision of what should exist for the chronically impaired, put into statute the basic principles and policy structure for moving in a preferred direction, and begin the process of preparing for a fundamental change in how health care is provided. Some of the key provisions that should be included in this umbrella policy are:

- a movement of LTC benefits funded under Medicaid into a new Medicare Part C;
- clarification of federal, state and private sector roles in the financing, administration and delivery of care;
- a commitment to standardize federal policy across the spectrum of programs serving the chronically impaired elderly;
- movement to a condition-based method of financing that recognizes the spectrum of hospital, nursing home, physician, and community-based options and gives providers incentives to collaborate and specialize in care of the chronically impaired elderly;
- recognition and support for family members as primary caretakers; and
- a commitment of funds to support research and development in finding new low tech/high touch solutions to chronic care.

I thank you for this opportunity to provide testimony on issues of long-term care and the elderly.

Chairman DURENBERGER. Well, thank you all very much, everyone on the panel and everyone who has participated today.

Let me say to everyone that I know it's not the beginning of anyone's participation. All of you who have come to this hearing have been at these hearings before or at other hearings or we would not be having this Commission, we would not be having this Commission hearing.

As I said in my opening statement, we have eliminated some important gaps in protection of elderly and disabled persons in America, but the most difficult problems remain. If we are a civilized Nation, and we all believe we are, although that's been challenged here today by a number of the witnesses, then we must rectify the shortcomings in the current health care delivery system that limit or prevent access of all persons in the United States to comprehensive health care.

It is the pledge of this Commission and it's 15 members that by November 9, 1989, we will have a report and recommendations to all of you and to all Americans on how that is to be accomplished.

For those of you who are interested, there will be more field hearings of the Commission. It's probably only a coincidence that some of these hearings will also be in other States of members of the Commission. Like Montana on June 30, any of you in Missoula. I mentioned that earlier. Those of you who might be around Cleveland, OH, on July 6, or Cincinnati, OH, on July 5, there will be Commission hearings in those communities as well.

We are now meeting every week, at least, in Washington. We have met with the National Leadership Commission to talk about their reports. And we will later this summer and into the fall be holding hearings in Washington, DC, as well, and decisionmaking sessions of one kind or another leading up to the final report of the Commission on November 9.

I think probably you know the names of the people that are involved in the Commission's work itself. On the Senate Finance Committee in addition to myself is Jay Rockefeller from West Virginia, who is the chair of the Medicare Subcommittee now that the Democrats are in the majority and we're in the minority. That's the subcommittee of which I am the ranking Republican. Also Senator Baucus from Montana and Senator Heinz from Pennsylvania, both of whom have had longstanding interest in these areas. And Senator David Pryor from Arkansas, who is currently the chairman of the Senate Select Committee on Aging. Then of course the person who has had an interest in these issues as long as anybody in the Congress of the United States, other than the current Chairman Congressman Pepper, is the chairman of the new committee that I am on now, the Labor and Human Resources Committee, Senator Teddy Kennedy of Massachusetts. And that represents the six Members of the U.S. Senate, the most knowledgeable on these issues in the Senate.

On the House side the chair and the ranking member of the Health Subcommittee of the Ways and Means Committee, which is the tax writing and the Medicare committee of the House of Representatives, Congressman Pete Stark, who comes from the San Francisco area of California. And Congressman Bill Gradison, whom you saw on television this morning, he is a Republican, and

he is from Cincinnati, OH. Then in addition to Senator/Congressman Pepper who is chairman of the Rules Committee, the Congressman who is responsible for Medicaid legislation on the House side and is a member of the Energy and Commerce Committee and chair of its Health Subcommittee is Congressman Henry Waxman who comes from the Los Angeles area of California. And also Congressman Tom Tauke, I think he gets in there through Energy and Commerce, doesn't he, from Iowa. Tom Tauke, a very, very excellent young Congressman from the State of Iowa. Congresswoman Mary Rose Oakar from the Cleveland area, I believe, of Ohio.

And those are the 12 congressional members of the Commission. And there are three other lay persons who were appointed by the President to be part of that Commission.

All of you and those who couldn't come here today will have further opportunities to be involved in the work of the Commission.

I introduced you earlier to Mary Edwards who is on my staff here in Minnesota. Mary, would you just stand up so that, in case anybody doesn't know you, they can see you.

And also the new person on my staff who is doing all of my health policy work in Washington, DC, who is not new to this field because she worked many years at the Department of Health and Human Services in a variety of areas, is Kathy Means. Kathy is right here.

And there are a variety of other people with whom you will be in touch over time on my staff. And we will be in touch with you via the normal means of communications so that those of you—Marge Simpson over here has—Maxine Simpson over here wants——

Ms. SINGSAAS. Singsaas.

Chairman DURENBERGER. What?

Ms. SINGSAAS. Singsaas.

Chairman DURENBERGER. Yeah. She wants to talk to me about Alaska, comparing Minnesota and Alaska.

Now, lots of you in this room have other ideas generated by this meeting, and we will find the way over the next 5 months to permit all of you to play a role in the work that this Commission is going to be developing. Because once November 9 comes, that's the foundation for the sign up there and all of the work that you people have been putting in over the years, that's the foundation on which to build. And I can't think of a better foundation for it to have than a Minnesota foundation.

Let me conclude by again thanking Dr. Reinertsen who made this place possible, Marge Canning who carried out that responsibility, Marge Stein who has made it possible for at least 100 or more people who couldn't get into this room to be with us today via video, Cheryl Wolfes for the communications and public relations, and everybody who is part of Park Nicollet here. They walked to work, parked their cars someplace else, so a lot of you guests would have more convenient parking here today.

And then also, without leaving anybody out, I just have to mention Peter Wykoff and the Senior Federation because I suspect Peter and the Federation had some hand in making sure that the buses got out and some folks got here. And it just can't be a mistake with all of these pennants and all that sort of thing. And

somewhere in there I see the Federation's fine, fine hand. We thank you all. Thank you very much. [Applause.]

Thank you panelists.

The hearing is adjourned. Thank you.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

APPENDIX

LINDA BERGLIN
Senator 60th District
G-29 State Capitol Building
St. Paul, Minnesota 55155
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Senate
State of Minnesota

May 25, 1989

The Honorable Senator Dave Durenberger, Vice Chair
U.S. Bi-Partisan Commission on
Comprehensive Health Care
Park Nicollet Medical Center Auditorium
5000 West 39th Street
St. Louis Park, Minnesota

Testimony by Senator Linda Berglin, Chair
Minnesota Senate Health and Human Services Committee

It is a major failure of our advanced society that so many Americans go without access to quality health care. Although it is hard to know exactly how many of our fellow citizens suffer without health care -- mainly because so many of them are homeless -- one estimate puts the number at 37 million, a sum which I believe to be conservative.

In Minnesota alone, about 342,000 people are uninsured -- without access to quality health care -- at any one time. Most of them are under age 45, and more than three-quarters of them are employed all or part of the year. It is a tragedy that this group has twice the death rate as people the same age who do have health care coverage.

Besides the cost in terms of human suffering and illness, which alone is tremendous, the fact that so many Minnesotans are uninsured "costs" society in many other ways. Hospitals must "eat" or pass on the cost of uncompensated care -- costs which tend to be high because uninsured people don't seek treatment until the problem is severe. State costs for General Assistance

and Medical Assistance programs increase, for it can take only one illness or injury to cause a working person to lose their job and be forced back onto welfare. Everyone's health insurance costs go up, because this situation fuels the inflation of medical costs in general.

The core problem is lack of affordable health care. It is a problem which requires a comprehensive solution.

This year, I sponsored legislation that would have required all Minnesotans to have health care coverage by July of 1990. The bill would have set required levels of basic care to be provided by all health plans, and would have created a state-run health plan to insure those otherwise uninsured. Employers that didn't offer health benefits would have had incentives to begin doing so. The new system would have been financed through a combination of general fund appropriation, patient co-payments and a payroll tax.

The bill was not passed in its original form; mainly because, I believe, this is such an overwhelming problem and many people just don't feel we have the resources to address it on the state level.

Federal initiative is sorely needed. There certainly is precedent for such initiative. The federal government has intervened in this way before, with Social Security and a host of federally-sponsored maternal and child health programs. And rightly so, for those are areas of concern to the nation as a whole.

Access to health care deserves the same treatment. It is a national problem that so many Americans go without health care; it is a national disgrace. Congress should either decide to take on the issue at the federal level, or, perhaps more logically, to increase funding to states to improve health care access as needed in each state.

Either way, Congressional action would be a welcome sight. I urge the commission to seriously consider this type of federal intervention, for such intervention could go far in giving all Americans something to which they have a right: quality, affordable health care.

-END-

LONG TERM CARE TASK FORCE

FINAL REPORT AND RECOMMENDATIONS

June 1989

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BACKGROUND AND TASK FORCE MEMBERS

The Minnesota Coalition on Health Board of Directors assembled the Long Term Care Task Force in February 1988 in recognition of an increasingly urgent need for a community consensus on how long term care for the elderly will be financed and delivered in the future.

The Task Force, made up of representatives from business, health care providers, government, researchers, insurers, and community organizations, met from February 1988 to February 1989. Throughout its discussions, the Task Force emphasized the importance of maintaining individual autonomy; encouraging innovation and flexibility in long term care services; and promoting cooperative efforts among individuals, corporations, and governmental bodies in this area. The Coalition's Board of Directors approved this report on May 12, 1989.

The Minnesota Coalition Board of Directors wishes to thank the following members of the Task Force for their efforts in this endeavor:

Chair
Mark A. Peterson
President
Lutheran Social Service of Minnesota

Robert Armitage
Executive Director
Board of Social Ministry

Jay Boekhoff
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TPF&C Tillinghast

Carl Carlson
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David Christianson
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Lutheran Brotherhood

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John Drozdal
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Robert Perkins
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Dakota County

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INTRODUCTION

Long Term Care includes health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity. The focus of the Long Term Care Task Force of the Minnesota Coalition on Health is on the elderly and their long term care needs.

As a first step in identifying needed changes in long term care, the Task Force developed the following vision of what Minnesota's long term system and its goals should be.

Minnesota's long term care services should be available in a variety of settings. The long term care system should strive to provide services in the least restrictive environment. In this way, an individual's long term care needs may be more routinely and adequately met in physical surroundings preferred by individuals and their families.

Long term care services should be developed to utilize and support existing informal support networks to the fullest extent possible. The exact amount of long term care services provided by informal caregivers such as family members and friends is unknown. Several Metropolitan Council studies have found, however, that between 85 and 95 percent of all services provided to the elderly are provided by family or friends.[1] The continued involvement of these informal caregivers should be encouraged and supported, but not mandated, by public policy.

Agencies that currently provide formal services must accommodate and complement informal support and concentrate on meeting needs that informal caregivers are unable to address. In light of the growing elderly population and the subsequent demands that will be placed on the medical professions, utilization of paraprofessional caregivers who are trained to provide basic health and personal care services should be explored. Keeping in mind the nation's declining labor supply, the long term care field should also recognize that it will be forced to be competitive with other employers in terms of salary and benefits in order to attract personnel.

In addition to having a choice of environments in which to receive services, consumers should be able to select a variety of long term care services which can be easily integrated and organized. Participants in Minnesota's long term care system, including regulators, administrators, and providers, must be encouraged to integrate their efforts in order to better serve consumers.

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[1]Reshaping Long Term Care in the Metropolitan Area: Recommendations for Change; Publication No. 14-85-023, May 1985, p. 20.

Ultimately, major changes in long term care service delivery and financing policies at the state level depend upon federal government action. The Long Term Care Task Force agrees that serious reform of the nation's long term care system must be undertaken at the federal level. While it acknowledges that this is true, the Task Force chose to focus on recommending activities which can begin to be pursued at the state level while long term care system reform is being debated nationally. The Task Force considers the following principles to be crucial in the formulation of long term care public policy. Specific recommendations are discussed in further detail in subsequent sections of the report.

GOALS FOR MINNESOTA'S LONG TERM SERVICES

Long term care services should preserve people's sense of privacy, autonomy, personal responsibility, and control.

Individuals have varying levels of need for long term care services and the long term care system must accommodate these differences instead of forcing people to choose among inappropriate service alternatives. Individual preferences should be an important component in any decisions made related to long term care.

Long term care services should strive to maintain or improve a person's functional status in order to maximize the ability to function independently.

Elderly persons can benefit from services which build upon, support, and strengthen their existing functional abilities. Depending on the individual consumer's preferences, long term care services whose goals range from maintenance to rehabilitation should be accessible.

Innovation in the structure, delivery, financing, and evaluation of long term care services should be emphasized and encouraged.

In order to address the complex problems of providing long term care services to Minnesota's citizens, it is vitally important to encourage new ideas and programs regarding service delivery, quality assessment, and funding of long term care services. Such options as experimental pilot projects and the use of waivers to encourage programmatic flexibility should be utilized. Support of innovative approaches in long term care will require the involvement of government, business, and community organizations.

Access to long term care services should not be limited by income and personal resources.

There is an urgent need for a public discussion of a) the proper combination of public and private funding for long term care service, and b) which services should be available to all people regardless of personal finances. A formula for an equitable sharing of increasing long term care expenses must be developed.

In order to achieve the above reforms in long term care,

Individuals, corporations, and governmental bodies should recognize the growing need for long term care services and the necessity to work cooperatively in an effort to meet this need.

The provision of long term care services must be a concern of both the public and private sectors. Consequently, coordination of service delivery, funding, or other facets of the long term care system should be developed.

RESHAPING THE DELIVERY AND FINANCING OF LONG TERM CARE: RECOMMENDATIONS AND DISCUSSION

In keeping with the above-stated goals, the Task Force has identified the following key components of long term care which heavily affect on the elderly's personal autonomy and independence.

I. QUALITY ASSURANCE AND THE PAYMENT SYSTEM

Quality standards for long term care services should change toward focusing on the outcomes of services rather than structural requirements. When attempting to measure the quality of long term care services, concern about an individual's quality of life (including the maintenance of personal control and choice) must be merged with concerns about technical quality. The most appropriate service may not be the most technically advanced intervention but rather a less intrusive alternative which is more conducive to an individual's preferred lifestyle. Greater flexibility is needed regarding who provides services and where they are provided in order to respond adequately to individual needs and to provide better care.

Maintenance or improvement in a person's ability to function independently is crucial in a long term care system which highly values individual choice and autonomy. Providers who achieve better than expected outcomes should receive financial rewards that are built into funding mechanisms. Providers must also be encouraged to recognize the right of consumers to make personal decisions regarding their care and should work closely with the individual client in order to agree on the goals of the long term care services.

Quality of care remains a critical, if elusive, goals for long term care. Before considering changes in resource allocation, it is important to address the question of whether current funds are being spent wisely. There is at once a growing demand for more creativity and more accountability in long term care. It may be possible to reduce the regulatory burden, increase meaningful accountability, and make the incentives within the system more rational.

There are several reasons for looking toward outcomes as the way to assess and assure quality:

- Outcomes encourage creativity by focusing beyond current professional standards or the beliefs of powerful constituencies.

- Outcomes permit flexibility in the modality of care.

- Outcomes permit comparisons of effectiveness across types of care.

- Outcomes permit more flexible responses to different levels of performance, and thus avoid the "all-or-none" difficulties of many sanctions.

At the same time, outcomes have some limitations:

- Outcomes require a single point of accountability; all the actors -- facility operators, agencies, staff, physicians, patients, and family -- contribute to outcomes. Under this approach the role of the accountable provider includes motivating others.

- Outcomes are largely influenced by the patient's status at the beginning of treatment, therefore, the actual outcomes achieved may not be a fair measure of provider performance. The easiest and most direct way to address this issue is to use the ratio of achieved to expected outcomes as the measure of success. In this document, "outcomes" is used to mean the ratio of achieved to expected outcomes.

The outcome approach can be used in several ways.

- There is already growing national interest in increasing the emphasis on outcomes in regulatory activities. Outcome measures can be substituted for most of the current structure and process measures. By emphasizing outcomes, regulatory burdens would be reduced. It is important to recognize, however, that it is NOT appropriate to dictate structure, process, and outcome at the same time. Such a policy would remove all degrees of freedom and stifle creativity at the very point when it should be encouraged. Under an outcome regulated approach, providers whose clients do better than expected are rewarded and less concern is directed to the style of their caregiving. Those whose clients do relatively poorly are investigated more closely.

- Outcomes can be incorporated into the payment structure to tie closer together the payment and the effects of care. Payments, either in the form of bonuses and penalties or as a more fundamental part of the payment structure, can be used to reward and penalize good and bad outcomes, respectively. (For example, an outcome approach might use the overall achieved-to-expected ratio for a client as a multiplier against the costs of care to develop a total price paid for that period of time; or one might use a similar ratio to weight the amount of money going to a given provider from a fixed pool of dollars committed to such care.) 6

Such an approach must be viewed carefully within the context of Minnesota's present case-mix reimbursement scheme for nursing homes. An outcome approach to payment is compatible with a case-mix approach that is used on admission only.

- An outcome approach can be incorporated into the basic caring process. By structuring the information base used in assessing clients and developing care plans, the emphasis on outcomes can become a proactive force to guide care. In the best situation, the information used to assess outcomes will come from the clinical records and will be the same information used to plan and deliver care. Using available computer technology it is feasible today to collect such information, translate it into care plans, and aggregate it for the quality assurance at minimal additional costs. The great advantage of such a scheme is its potential both to provide a better information base to plan care and to reinforce the creative use of such information to achieve improvements in function. Much of the current effort going into more traditional regulatory activities might be redirected to this effort, with government oversight used to validate functional assessments of patients and to focus more intense efforts where outcomes are less than expected.

There is generally good consensus on the components of outcomes and less good consensus on how to combine them. The gerontologic literature consistently cites the following as outcomes: physiologic function (e.g., blood pressure control), functional status (usually some measure of activities of daily living), pain and discomfort, cognition (intellectual activity), affect (emotional activity), social participation (based on patients' real preferences), social relations (at least one person who can act as a confidant), satisfaction (with care and living environment). To these must be added more global outcomes such as death and admission to a hospital.

Research has been done with nursing home patients to show that these factors can be predicted with sufficient accuracy to be used in a regulatory model. Similarly, research has shown that there is reasonable consensus across a wide variety of constituencies about the relative weights to be placed on the various factors for different kinds of clients (e.g., clients with different starting levels of physical and cognitive function).

The outcomes approach offers significant assistance with a recurrent problem in regulation, namely, the development of standards. This approach may avoid many of the difficulties by relying on empirical standards. Rather than arguing about what should be the standard, the performance of all providers can be used as a norm. Accordingly, expectations can be derived from the actual outcomes associated with real care given by those felt to represent a reasonable level of practice. This could include all providers or a designated subset. Under this

arrangement, providers would be comparing their achievements to each other's past records, but with the possibility that everyone can do better.

Recommendations for Federal and State Action:

1. **Outcomes should be used as the basis for quality assurance in long term care. This approach can be incorporated into regulatory activities, the payment structure, and the basic caring process.**

2. **Long term care reimbursement should, at least in part, be outcome-based, rewarding providers for optimizing a person's health and functional status in accordance with agreed upon goals. The Task Force recommends that, as a first step toward an outcome-based reimbursement system, an outcome-based payment approach be implemented in a nursing home payment demonstration project.**

An outcome-based reimbursement system, because it is so innovative, should be tested in a carefully planned demonstration project in a limited number of homes. For example, a randomly designated half the homes would be paid and regulated under this new approach while the other half continued under the present system. Careful monitoring of both groups will demonstrate whether the anticipated changes in provider behavior are achieved. Part of the demonstration would require a waiver to permit the removal of most other regulatory burdens from the experimental homes to emphasize the attention to outcomes and allow the homes more freedom to innovate.

II. SOURCES OF FINANCING

The need for long term care services will continue to grow in the future as the percentage of elderly citizens increases. By the year 2010, 14 percent of Minnesota's population will be elderly (65 years and over) with 17 percent of this older population being 85 years and over. Concurrently, the cost of long term care services will continue increasing rapidly. Nationally, for example, nursing home costs are expected to grow an annual 4-7 percent above inflation through at least the year 1990.[2] Because of this growing societal need and the high costs of services, the government, employers, and individuals share responsibility for anticipating the demand for and financing of long term care services.

In order to maximize the personal choice and autonomy of individuals, public funding for a wide variety of long term care services should be available and accessible. The opportunity for people to assemble a package of long term care services which is most appropriate for them should not be forfeited due to overly strict and rigid funding requirements. Comparative costs should be an important factor in choosing among alternative services, but should not be the only factor. Choice should be encouraged within care alternatives when the costs are essentially equivalent or where there is a clear benefit of one approach over another.

However, as the demand for long term care services increases, it is reasonable to assume that public dollars will be increasingly targeted at those people who need the most financial help in paying for services. Individuals, their families, and corporations should be strongly encouraged to anticipate the need for long term care services and plan the use of their resources accordingly. Pre-funding should be encouraged for both private and public financing. Funding mechanisms which allow the linkage and coordination of private and public funding should be promoted.

There is some confusion about the current status of long term care financing. In general terms, although family and friends provide the bulk of total long term care, public funds pay about 50 percent of the nursing home bill but support about 70 percent of the residents. This discrepancy reflects the unrecognized but substantial contributions to care costs that persons receiving government support continue to pay out of their own pockets and from such sources as Social Security. This picture also implies that the gap between a universal program of long

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[2]United States Senate, Special Committee on Aging. Developments in Aging: 1986. Volume 1. Washington D.C.: U.S. Government Printing Officer, 1987.

term care coverage and today's picture is not as great as it seems. Although it appears that the government must pay the other 50 percent, there are already government funds being directed to support nursing home care.

There is consensus about the desirability of developing a more effective mix of public and private financing of long term care. The more difficult question is how those components should be mixed. Current proposals to move beyond the present system of spending down to become eligible for welfare coverage include a government financing role after a period of private payment (in essence a large deductible) for institutional care or a shared financing of private long term care insurance through direct assistance or tax credits.

The Task Force recommends another way to view the situation. The current touchstone for long term care is the nursing home. Its fundamental components can be addressed separately. One can envision an independent set of long term care services (including but not limited to nursing and homemaking), with varying intensity depending on client needs, and a separate set of accommodation and meal services. The former should not depend on a client's income in any way that threatens access to these services. The latter can vary from a minimum designed to assure an acceptable housing standard to levels of more luxurious accommodations and amenities. This separation provides a socially acceptable set of incentives against which to build a flexible plan for savings and insurance. Under this approach, persons who have more resources (through thrift or good fortune) can enjoy a higher standard of living in their old age, but all will be assured of basic long term care services.

Encouraging savings responds to another concern, namely the importance of pre-funding elements of long term care. The anxiety around the effects of demographic projections into the next century argue forcefully that future retirees should establish resources to support their retirement in a way that will maintain their financial as well as their functional independence as long as possible. At the same time, some means must be found to assist the current and soon-to-be retirees. Pre-funding can be encouraged through individual and employer-sponsored savings plans or insurance policies. Innovative mechanisms to convert current insurance assets may provide some assistance to those about to retire.

For individuals and employers, incentives are needed to encourage savings that can be used to fund long term care services. The Task Force urges that legislators and policymakers explore and encourage the use of currently existing savings programs, such as 401(k)s, expanded IRAs, annuities, and life insurance policies, coupled with tax-favored treatment of disbursements from savings if they are used for qualified long term care expenses as defined by the federal and state government.

The issue is not simply one of encouraging saving, however. Today's elderly come from a generation that has saved diligently. Unfortunately, the current arrangements penalize that thrift by insisting that the individual first spend his/her own resources to the point of poverty before he/she becomes eligible for government assistance with long term care expenses. At the same time, there are strong feelings that public funds should not be used while older persons preserve their assets to form a legacy. The Task Force proposals seek to find a middle ground that provides both a floor for service and the potential to use one's resources to purchase more elaborate care.

Recommendations for Federal and State Action:

3. **Modify existing regulations for nursing homes to allow greater "unbundling" of services between housing (board and care) and long term care services per se. In essence, expand the use of assisted living approaches, and develop quality standards compatible with that approach to care.**

   This approach will initially require waivers to permit experimentation. There is considerable and growing experience with assisted living approaches to demonstrate the potential for more flexible funding. Good models of this approach are already available in Minnesota in the private market. More work is needed to develop appropriate ways to assure quality of care under these more flexible arrangements.

4. **Allow expanded tax deductions for IRA contributions (in order to encourage personal saving) along with favorable tax treatment for distributions of IRA/401(k) savings used for designated long term care services.**

Recommendations for State Action:

Modify Minnesota's insurance regulations to:

5. **Allow long term care benefits to be packaged with other kinds of benefits. Such a modification would permit the existence of "multiple benefit" products which would provide an alternative benefit (e.g., death benefit, return of premium, or an accelerated benefit) if the long term care benefits were never used by the insured.**

6. **Expand the range of long term care policies available. Proper labeling of coverage such as qualified or non-qualified plans can identify plans where benefits are more limited than under policies currently allowed.**

At the state level, the Minnesota Department of Commerce, the Legislature, the insurance industry, and private employers should take a greater role in expanding the availability and variety of insurance options. Proper consumer protection and education efforts should

accompany any expansion of the insurance market. At the federal level, financial incentives which encourage the purchase of insurance should be explored.

The proposed enriched insurance products would overcome the objection of "What happens if I never need the coverage?" Currently, the average age of a purchaser of long term care insurance is 73 years. In order to assure the viability of long term care insurance products, an adequate market of insurable individuals is required. This adequate market needs to include younger purchasers (e.g., those in the 40s and 50s) as well as post-retiree individuals.

Recommendation for Interested Parties Action

7. **Consider linking the delivery of adult daycare with schools. This linkage would allow schools to receive extra funding and utilize empty building space while providing a stimulating environment for the elderly.**

III. ACCESS TO LONG TERM CARE INFORMATION

As stated previously in this report, families and friends continue to provide a large number of support services to the elderly. At the same time, many of these informal caregivers have a variety of other responsibilities such as children and employment outside of the home.

When a caregiver requires information about formal long term care services, the need is usually immediate due to a hospitalization or a deterioration of functional ability on the part of the elderly family member. Often the caregiver has not explored formal long term care alternatives prior to this time and is faced with having to make important decisions with little understanding of their options. Attempting to gather information about appropriate services and funding sources can be a frustrating, time-consuming, and stressful experience.

In an attempt to facilitate this information-gathering process, the Task Force recommends that employers explore the possibility of providing long term care information and referral services in the workplace.

Recommendation for State Action:

8. **Provision by employers (through contracts with local agencies) of information, referral, and assessment services for employees caring for older relatives. These services would assist employees who are caring for seniors by providing information on long term care resources which will help alleviate their caregiving burden and thus reduce the loss of efficiency on the job.**

The availability of this kind of short-term connecting link through employers would be an effective way of making long term care information available to the largest number of individuals state-wide. It would also make use of already existing information and referral services (such as Area Agencies on Aging telephone referrals and publications or First Call for Help) by tying more people into this network. Area Agencies on Aging currently exist in every county of Minnesota and could serve as a valuable resource for employers in this endeavor as could ombudsman and county pre-admission screening services.

The specific service to be provided would be information, referral, and assessment for the caregiver who needs help in evaluating their particular needs; information regarding the viable solutions; and objective appraisals of each alternative. This service would be funded by sponsoring employers through contracts with agencies such as those cited above.

In addition to this recommendation, we urge other members of the community who are frequently in contact with the elderly and their family members, such as doctors, acute care hospitals, and churches, to become aware of long term care service alternatives and to actively dispense existing information to their constituents.

SUMMARY OF RECOMMENDATIONS

1. Outcomes should be used as the basis for quality assurance in long term care. This approach can be incorporated into regulatory activities, the payment structure, and the basic caring process.

2. Long term care reimbursement should, at least in part, be outcome-based, rewarding providers for optimizing a person's health and functional status in accordance with agreed upon goals. The task force recommends that, as a first step toward an outcome-based reimbursement system, an outcome-based payment approach be implemented in a nursing home payment demonstration project.

3. Modify existing regulations for nursing homes to allow greater "unbundling" of services between housing (board and care) and long term care services per se. In essence, expand the use of assisted living approaches, and develop quality standards compatible with that approach to care.

4. Allow expanded tax deductions for IRA contributions (in order to encourage personal saving) along with favorable tax treatment for distributions of IRA/401(k) savings used for designated long term care services.

5. Allow long term care benefits to be packaged with other kinds of benefits. Such a modification would permit the existence of "multiple benefit" products which would provide an alternative benefit (e.g., death benefit, return of premium, or an accelerated benefit) if the long term care benefits were never used by the insured.

6. Expand the range of long term care policies available. Proper labeling of coverage such as qualified or non-qualified plans can identify plans where benefits are more limited than under policies currently allowed.

7. Consider linking the delivery of adult daycare with schools. This linkage would allow schools to receive extra funding and utilize empty building space while providing a stimulating environment for the elderly.

8. Provision by employers (through contracts with local agencies) of information, referral, and assessment services for employees caring for older relatives. These services would assist employees who are caring for seniors by providing information on long term care resources which will help alleviate their caregiving burden and thus reduce the loss of efficiency on the job.

ABOUT THE COALITION

The Minnesota Coalition on Health is a consortium of employers, labor, consumers, health care providers, insurers, HMOs, and government concerned with the cost, quality, and access to health care. The Coalition was established as a public, non-profit corporation in 1980 to foster cooperation on issues arising in the health care market.

The Coalition believes that the goals of the health care system are to promote health and wellness, and, when needed, humane, high-quality care at a reasonable cost for all Minnesotans. It believes these goals are inseparable and can best be achieved through a health care system that relies upon incentives, informed choices, innovation, and shared responsibility among the purchasers, providers, managers and recipients of care.

The Coalition:

- addresses major trends and issues affecting health care cost, quality and access;
- serves as a forum for the diverse views in the community;
- works to reconcile divergent interests with a larger vision of the community good;
- develops policy positions, as approved by the Executive Committee and the Board of Directors, and
- when appropriate, acts, or facilitates the actions of others, to promote its policy positions.

ERLING M. WEIBERG
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24 May 1989

Chairman
U.S. Bipartisan Commission on
Comprehenisve Health Care
Park Nicollet Medical Center Auditorium
St. Louis Park
Minnesota

Dear Sir:

My name is Erling M Weiberg, address above. My age is 71. I am retired, pay monthly medicare premiums and supplement my health care situation by paying an annual premium to Blue Cross/ Blue Shield. Further, I will pay by April 15, 1990, a surtax for catastrophic health costs that could befall me in the future.

My concern at your hearing today is with the need for comprehensive health care services for all uninsured citizens of this country. It is my opinion that proper health care is a right of all citizens of this nation. It is in public welfare that all citizens receive health care so as to contribute to the well being of the general public of the United States. I beleive that a healthy citizen , who performs work for a life-time, contributes to the nation's public benefit. With access to proper health care for a life time the benefits should be

greater than the costs to the individual (taxes), the community and the nation.

We have a 30 year old college educated daughter, who owns a small yarn store. She is self-employed. By the time she pays business expenses, designs advertising, handles buying of inventory and pays living expenses, profits are insufficient to purchase high-cost premiums for medical insurance. That is her opinion. She has operated her yarn store for seven years, works 9 hours per day for 6 days a week, and drives a small U.S. car, now ten years old.

She is generally in good health now, but heavy responsibility as a sole owner of her business, plus long hours has resulted in some lost time because of sickness.

I do not want my daughter denied medical care nor do I want her health care costs to be so large that she denies herself the care of the medical profession to protect her .

My daughter tells me now that last year her premium for health insurance a month would have been $89.00 - over $1000 a year.

I think every taxpayer should have an appropriate surtax box on the tax form to finance this health need of this nation.

Respectfully yours,

Edna Weisberg

Commission Members:

My name is Sandy Manderfeld. I'm Coordinator of the Senior Helping Hands Program located at the St. Cloud Hospital in St. Cloud. Our main thrust is working with seniors who may be experiencing chemical dependency or mental health problems. Today I'm speaking on behalf of the St. Cloud Hospital.

As of January 1st, Senior Helping Hands has become the administrator of a program called Central MN. Physcians Serving Seniors, which helps provide more affordable health care to low income seniors through voluntary assignment of Medicare by participating physicians. Since its inception a few months ago, we have found that 28% of the 328 seniors who have applied do not have medigap supplemental insurance-- I'm speaking of both couples and individuals. Based on our information, we have also found that 56% of the applicants have an annual income of between $4,000-$9,500. These low income seniors find the cost of health care a barrier to health care access and even those who have medigap insurance are denying themselves necessities to pay for the premiums which are continually going up. It's a fallacy to think that just because low income seniors have Medicaid or Medicare benefits that they access to quality health care.

The St. Cloud Hospital is concerned. We would like to see legislation concerning this issue, as state funding will not be enough to aid the growing numbers of uninsured--whether they are the younger or older population. As a nation, we should be able to assure equitable access and quality health care to all our citizens!

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